

Amend Item #10B 20C G773 7-22-99 EW. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND: ITEM: #26 PER MD G773 7-22-99 WK. State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #10A-B, 10E-F PER F.H. #26 PER MD G773

# Certificate of Death

Reg. No.

99 16001

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Michael M. Jaller</b>				2. Date of Death Month Day Year <b>April 29, 1999</b>		3. Time of Death <b>2:45 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>10500 Burbank Drive</b>				4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>089-20-1680</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b>	8. Date of Birth (Month, Day, Year) <b>Feb. 25, 1924</b>	9. Birthplace (State or Foreign Country) <b>Switzerland</b>		
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>BREVARD</b>		10c. City, Town or Location <b>Potomac</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>10500 Burbank Drive</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Physician</b>		16b. Kind of Business/Industry <b>Medical</b>	
17. Father's Name (First, Middle, Last) <b>Arthur Jaller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Eliash</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Helen C. Jaller-Spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10500 Burbank Drive Potomac, MD 20854</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Judean Memorial Gardens</b>		20c. Date <b>5/2/99</b>		20d. Location - City or Town, State <b>OLNEY, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>Donald C. Stettin</b>				22. Name and Address of Facility <b>Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike Rockville, MD 20852</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Glioblastoma Multi-Forme</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____							
Approximate Interval Between Onset and Death <b>4 Mths</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>2ND RESIDENCE</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D39934</b>		29d. Date signed (Month, Day, Year) <b>May 1, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven T. Coulter, MD 15201 Shady Grove Rd #202 Rockville, MD 20850</b>							
31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>				32. Registrar's Signature <b>[Signature]</b>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16002

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERALDINE

JASON

2. Date of Death

May 1, 1999

3. Time of Death

10:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

062-12-5790

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 1, 1923

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15101 INTERLACHEN DRIVE

10f. Zip Code

20906

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JACK LEADER

18. Mother's Name (First, Middle, Maiden Surname)

RUTH RAPPAPORT LEADER

19a. Informant's Name/Relationship (Type, Print)

BEVERLY JASON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7707 FAWN COURT - DERWOOD, MARYLAND 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

JUDEAN MEMORIAL GARDEN

Date

5/4/99

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. MYASTHENIA GRAVIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D23459

29d. Date signed (Month, Day, Year)

MAY 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWARD P. TAUBMAN - 18111 PRINCE PHILIP DRIVE - OLNEY, MARYLAND 20832

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

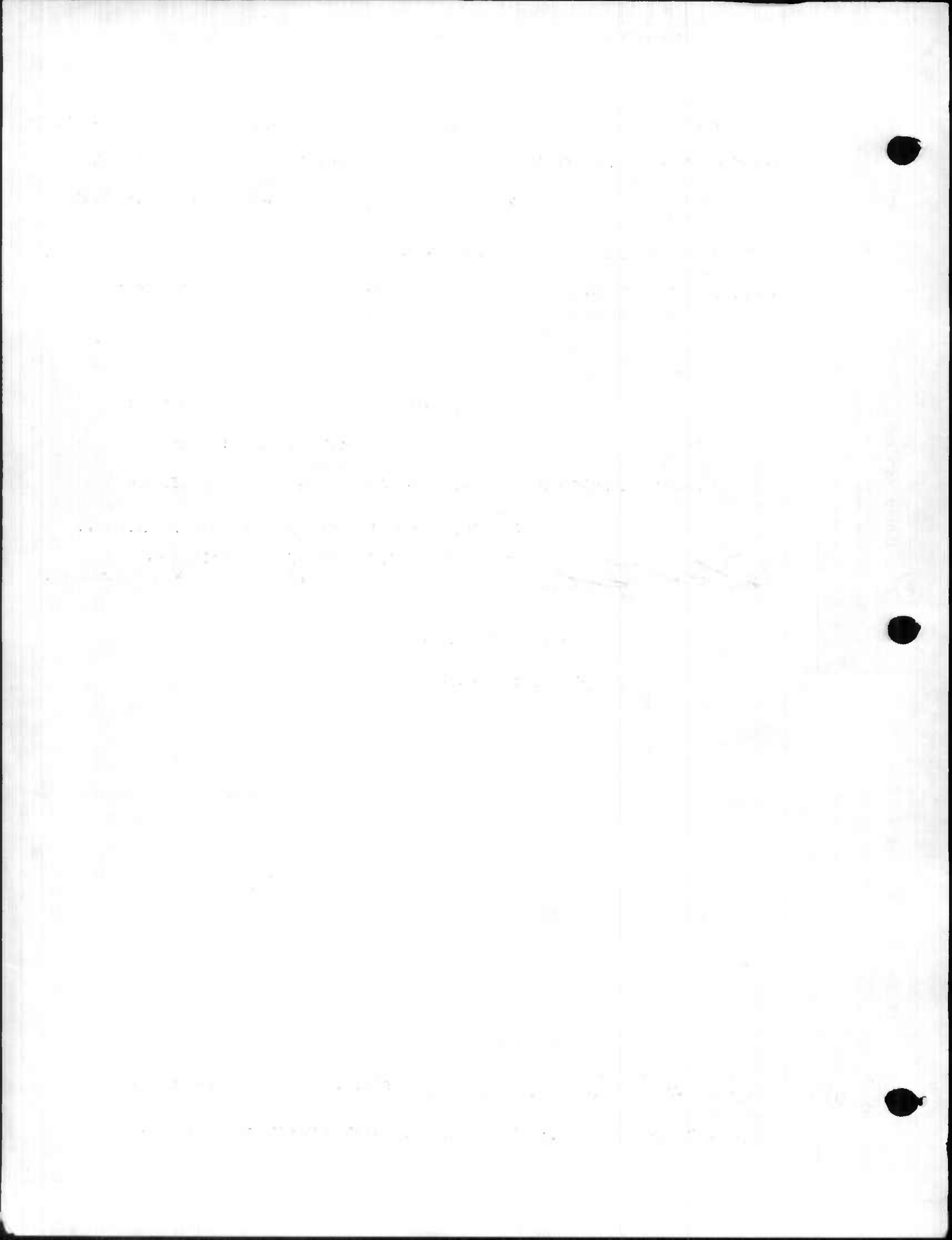
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #19a, 5/11/99, BMW, Montg. Co.

## Certificate of Death

Reg. No.

99 16003

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Xili Jing

2. Date of Death

May 2, 1999

3. Time of Death

9:50PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

213-13-2578

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 24, 1930

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

199 Rollins Avenue, Apt. 504

10f. Zip Code

20852

10g. Citizen of What Country?

China

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Professor

16b. Kind of Business/Industry

University

17. Father's Name (First, Middle, Last)

Jiamai Jing

18. Mother's Name (First, Middle, Maiden Surname)

Fenglan Zhou

19a. Informant's Name/Relationship (Type, Print)

Qigui Chen/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

199 Rollins Avenue, Apt. 504, Rockville, MD 20852

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

May 4, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Daniel E. Perry M00803

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue,  
Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ovarian Cancer Stage IV

Approximate Interval Between Onset and Death

2 yr 4 months

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

a. Due to (or as a consequence of):  
Bilateral Pleural effusion and lung infiltrates

b. Due to (or as a consequence of):  
Sepsis

c. Due to (or as a consequence of):  
Bilateral Hydronephrosis

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Duodenal obstruction by tumor

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

N/A

28b. Time of Injury

N/A M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred

N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Zhi Yan MD

29c. License number

53544

29d. Date signed (Month, Day, Year)

05/02/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

4701 Randolph Road, Rockville, MD 20852

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16004

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

KATHERINE CONWAY JOHNSON

2. Date of Death

Month Day Year  
May 05 1999

3. Time of Death

10:40 AM

4a. Facility Name (If not institution, give street and number)

6 West End Ave.

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

213-42-2406

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 7 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6 West End Ave.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Harvey H. Conway

18. Mother's Name (First, Middle, Maiden Summa)

Sarah Catherine Willey

19a. Informant's Name/Relationship (Type, Print)

Eva Carol Willey - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 West End Ave. Cambridge MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Christ Churchyard

Date

5-7-1999

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

*Kenneth R. Thomas Jr.*

22. Name and Address of Facility

Thomas Funeral Home, PA

700 Locust St. Cambridge, MD 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Respiratory failure*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*2 minutes*

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Pleural effusion*

Due to (or as a consequence of):

*1 month*

c. *Pneumococcal pneumonia*

Due to (or as a consequence of):

*1 month*

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

*ASCLVD with recent non-Q-wave MI*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Mark Malkus, MD*

29c. License number

*DS0804*

29d. Date signed (Month, Day, Year)

*5/6/99*

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

*Mark Malkus, MD 408 Byrn St Cambridge, MD 21613*

31. Date filed (Month, Day, Year)

*MAY 07 1999*

32. Registrar's Signature

*Bonnie B. Sparks*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16005

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Helen M. Grace Johnson</b>				2. Date of Death Month <b>May</b> Day <b>3</b> Year <b>1999</b>		3. Time of Death <b>9:25PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Genesis ElderCare - The Pines</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
5. Social Security Number <b>216-14-9190</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04/30/10</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Sherwood</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7516 Tilghman Island Road</b>		10f. Zip Code <b>21665</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Picker/Processor</b>		16b. Kind of Business/Industry <b>Seafood Houses</b>			
17. Father's Name (First, Middle, Last) <b>Jacob Grace, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lavenia Bailey</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary Jane Smith/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21665 7516 Tilghman Island Rd., Sherwood, MD</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sherwood Cemetery</b>		Date <b>5/7/99</b>		20c. Location - City or Town, State <b>Sherwood, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>RENAL FAILURE</b> Due to (or as a consequence of): <b>DAYS</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>METASTATIC CANCER FROM COLON</b> Due to (or as a consequence of): <b>YEARS</b> <b>NON INSULIN DIABETES</b> Due to (or as a consequence of): <b>YEARS</b> <b>HYPERTENSION</b> Due to (or as a consequence of): <b>YEARS</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SENILE DEMENTIA</b> <b>HYPONATREMIA</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>448241</b>		29d. Date signed (Month, Day, Year) <b>5/4/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DANIEL E. MAKAS, 508 IDEWICH AVE EASTON, MD 21601.</b>							
31. Date filed (Month, Day, Year) <b>MAY 06 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 toll permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

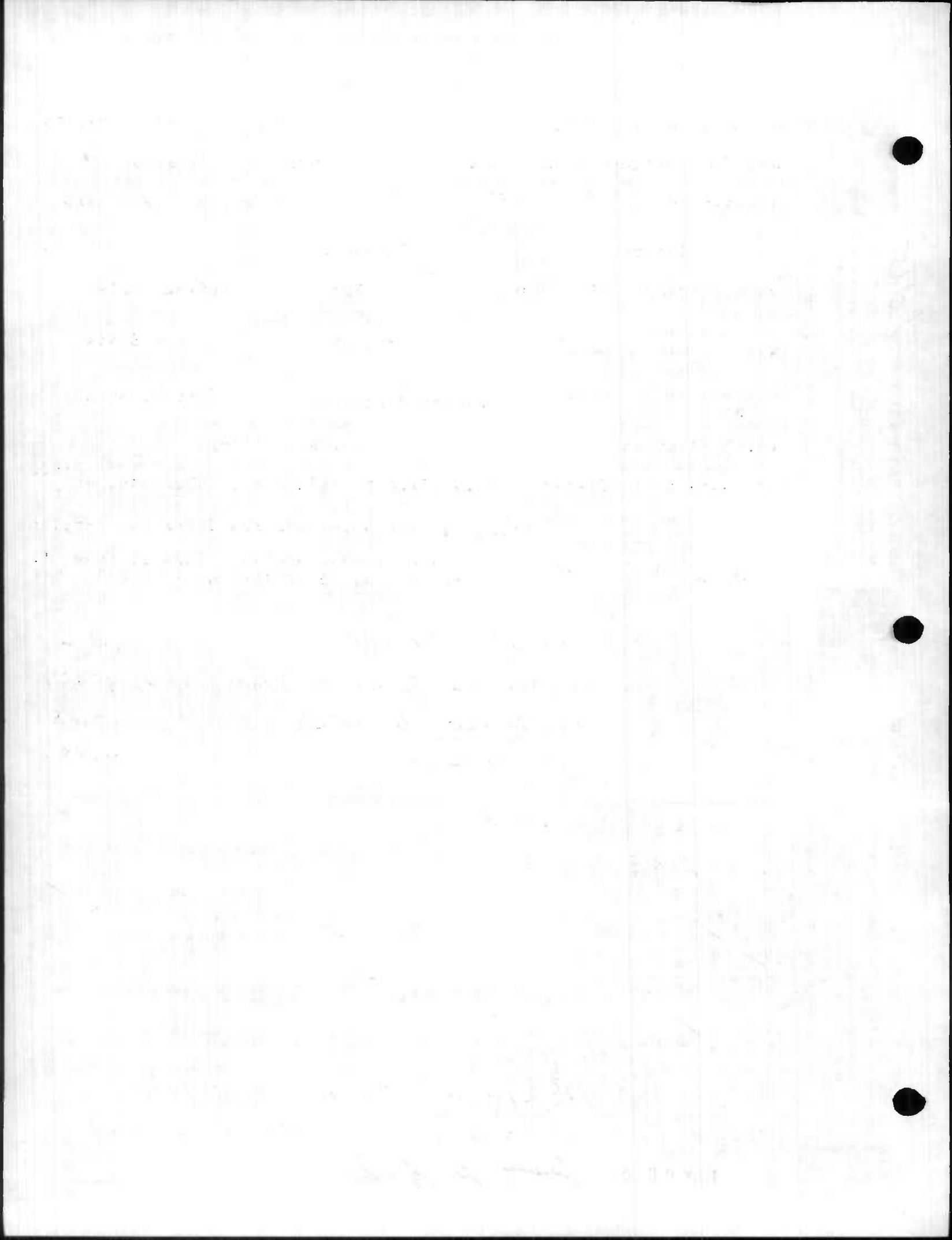
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar







Steven Charles Keenzler

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART 1, 27, 28A-F PER MEO G771 5-17-99 WR. Certificate of Death

Reg. No.

99 16006

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Steven Charles Krenzler				2. Date of Death Month Day Year April 25, 1999				3. Time of Death 5:38 A.M.					
	4a. Facility Name (If not institution, give street and number) 16003 Brandywine Road				4b. City, Town, or Location of Death Brandywine				4c. County of Death Prince George's					
Funeral Director	5. Social Security Number 219-72-3223		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 41 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Sept. 3, 1957		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent													
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Upper Marlboro				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10a. Street and Number 10911 Brookwood Avenue				10f. Zip Code 20772				10g. Citizen of What Country? USA					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Engineer				16b. Kind of Business/Industry Construction					
	17. Father's Name (First, Middle, Last) Bernhard Daniel Krenzler				18. Mother's Name (First, Middle, Maiden Surname) Dorothy P. Humes									
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bernhard D. Krenzler, Sr.-Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1313 Helvenston Street NW, Palm Bay, Fla 32907									
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery				Date 4-30-99		20c. Location - City or Town, State Clinton, MD			
	21. Signature of Funeral Service Licensee Mark G. Brohawn M00053				22. Name and Address of Facility Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, MD 20604-0156									
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE NARCOTIC INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last													
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene									
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) Found: 4-25-99		28b. Time of Injury Found: 5:10 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN HOUSE														
28f. Location (Street and Number or Rural Route Number, City or Town, State) 16003 BRANDYWINE ROAD BRANDYWINE, MARYLAND														
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier Dennis J. Chute, MD				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) April 26, 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201														
31. Date filed (Month, Day, Year) APR 28 1999				32. Registrar's Signature S. Sparks										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



WRC  
99-2484-031  
CHOON KANG  
KIM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 16007

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Choon Kang Kim				2. Date of Death Month Day Year APRIL 30, 1999				3. Time of Death 8:12 PM.		
	4a. Facility Name (If not institution, give street and number) HOLYWOOD RD. AND NEW HAMPSHIRE AVE.				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 217-90-7317		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) May 14, 1945		9. Birthplace (State or Foreign Country) South Korea		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 520 Norcross Way				10f. Zip Code 20904				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Asian			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner				16b. Kind of Business/Industry Dry Cleaner			
17. Father's Name (First, Middle, Last) Unobtainable				18. Mother's Name (First, Middle, Maiden Surname) Unobtainable							
19a. Informant's Name/Relationship (Type, Print) Mina Kim/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Norcross Way, Silver Spring, MD 20904							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial Park		Date May 11		20c. Location - City or Town, State Olney, MD					
21. Signature of Funeral Service Licensee Alamy Donnell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Multiple Injuries</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 4-30-99		28b. Time of Injury 1140 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred CAR AND POLE PASSENGER IN CAR, IMPACT WITH			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. Location (Street and Number or Rural Route Number, City or Town, State) HOLYWOOD RD. MONTGOMERY CO, MD									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Hoyte Melbule				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) MAY 01, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hoyte Melbule 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) MAY 04 1999		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



WRC  
99-2485-031  
DONG-YULL  
KIM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16008

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Dong Yull Kim				2. Date of Death Month Day Year APRIL 30, 1999				3. Time of Death 7:45 PM.	
4a. Facility Name (If not institution, give street and number) HOLYWOOD RD. AND NEW HAMPSHIRE AVE.				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death Montgomery	
5. Social Security Number 217-90-6082		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 25, 1943		9. Birthplace (State or Foreign Country) South Korea	
Usual Residence of Decedent									
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 520 Norcross Way				10f. Zip Code 20904		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Doctor			16b. Kind of Business/Industry Veterinary Medicine			
17. Father's Name (First, Middle, Last) Unobtainable				18. Mother's Name (First, Middle, Maiden Surname) Unobtainable					
19a. Informant's Name/Relationship (Type, Print) Mina Kim/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 Norcross Way, Silver Spring, MD 20904					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Norbeck Memorial Park		Date May 11		20c. Location - City or Town, State Olney, MD			
21. Signature of Funeral Service Licensee Alamy J. Donnell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 4-30-99		28b. Time of Injury 1940 P		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SCENE motor vehicle collision	
		28e. Place of Injury - At home, farm, street/factory, office building, etc. (Specify) street				28f. Location (Street and Number or Rural Route Number, City or Town, State) Silver Spring, Md			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dennis Chute, MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 01, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute, MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 04 1999				32. Registrar's Signature B. Sparks					

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16009

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALICE A. KOHNER				2. Date of Death Month Day Year MAY 1, 1999				3. Time of Death 8:30 PM										
	4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY										
Funeral Director	5. Social Security Number 331-22-8655		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) MAY 11, 1917		9. Birthplace (State or Foreign Country) VIRGINIA										
	Usual Residence of Decedent																		
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
10e. Street and Number 6121 MONTROSE ROAD				10f. Zip Code 20852				10g. Citizen of What Country? UNITED STATES											
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE				16b. Kind of Business/Industry OWN HOME											
17. Father's Name (First, Middle, Last) HYMAN LEVENSON						18. Mother's Name (First, Middle, Maiden Surname) MARY FUTRANSKY													
19a. Informant's Name/Relationship (Type, Print) SOL H. PELAVIN (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8813 TWIN CREEK COURT - POTOMAC, MARYLAND 20854															
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS		Date 5/5/99		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA											
21. Signature of Funeral Service Licensee Donald C. Stattemyer				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. ASPIRATION PNEUMONIA</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. DYSPHAGIA</td> <td>2 DAYS</td> </tr> <tr> <td>c. CEREBRAL ISCHEMIA</td> <td>MONTHS</td> </tr> <tr> <td>d.</td> <td>YEARS</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	Approximate Interval Between Onset and Death	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DYSPHAGIA	2 DAYS	c. CEREBRAL ISCHEMIA	MONTHS	d.	YEARS
Immediate Cause (Final disease or condition resulting in death)	a. ASPIRATION PNEUMONIA	Approximate Interval Between Onset and Death																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DYSPHAGIA	2 DAYS																	
	c. CEREBRAL ISCHEMIA	MONTHS																	
	d.	YEARS																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
				28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. Signature and title of certifier Steven Lipson MD				29c. License number D05885				29d. Date signed (Month, Day, Year) 05/02/99											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE																			
31. Date filed (Month, Day, Year) MAY 05 1999				32. Registrar's Signature B. Sparks															

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene



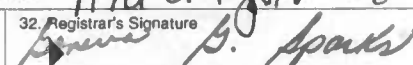
Certificate of Death

Reg. No.

99 16010

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>GEORGE WILLIAM KRAUS SR.</b>				2. Date of Death Month Day Year <b>APRIL 28, 1999</b>		3. Time of Death <b>8:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>4200 EAST WEST HIGHWAY</b>				4b. City, Town, or Location of Death <b>UNIVERSITY PARK</b>		4c. County of Death <b>PRINCE GEORGES</b>	
5. Social Security Number <b>577-01-5911</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 22, 1909</b>	
9. Birthplace (State or Foreign Country) <b>WASH. D.C.</b>		Usual Residence of Decedent					
10a. State <b>MD.</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>UNIVERSITY PARK</b>		10d. Inside City Limits <b>1 X Yes 2 No</b>	
10e. Street and Number <b>4200 EAST WEST HIGHWAY</b>				10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 No</b> If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 X Yes 2 No</b> Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>		College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SHOP FOREMAN</b>		16b. Kind of Business/Industry <b>FED. POWER COMMISSION</b>	
17. Father's Name (First, Middle, Last) <b>FRANCES X. KRAUS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELLA WILDING</b>			
19a. Informant's Name/Relationship (Type, Print) <b>JENNIE M. KRAUS/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>			
20a. Method of Disposition <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>4/29/99</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. <b>Cancer of The Lung</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>3 mos</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b>						23b. Did tobacco use contribute to the cause of death? <b>1 No 2 X Yes 3 Probably 4 Unknown</b>	
24a. Was an autopsy performed? <b>1 No 2 X Yes</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 No 2 X Yes</b>					
25. Was case referred to medical examiner? <b>1 Yes 2 X No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>					
27. Manner of Death <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. Signature and title of certifier 		29c. License number <b>D19431</b>		29d. Date signed (Month, Day, Year) <b>4/29/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frank M. Ryan MD 1170 Livingston Rd #203 Ft. Wash MD 20744</b>							
31. Date filed (Month, Day, Year) <b>MAY 03 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4+1

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

99 16011

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)  
Patricia Lewis Kidder

2. Date of Death  
May 3, 1999

3. Time of Death  
7:00 PM

4a. Facility Name (If not institution, give street and number)  
Carroll County Hospital

4b. City, Town, or Location of Death  
WESTMINSTER

4c. County of Death  
CARROLL

5. Social Security Number  
425-64-7843

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
68 Yrs.

8. Date of Birth (Month, Day, Year)  
FEB 12 1931

9. Birthplace (State or Foreign Country)  
MISS.

10a. State  
MD

10b. County  
CARROLL

10c. City, Town or Location  
WESTMINSTER

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
3421 FARMSTEAD DRIVE

10f. Zip Code  
21157

10g. Citizen of What Country?  
USA

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
TEACHER

16b. Kind of Business/Industry  
BOARD OF EDUCATION

17. Father's Name (First, Middle, Last)  
C.S. LEWIS

18. Mother's Name (First, Middle, Maiden Surname)  
COLAH MORROW

19a. Informant's Name/Relationship (Type, Print)  
PAUL S. KIDDER / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
3421 FARMSTEAD DRIVE  
WESTMINSTER, MD. 21157

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
EVERGREEN MEM GARDENS

20c. Location - City or Town, State  
5/4/99 FINKSBURG, MD.

21. Signature of Funeral Service Licensee  
PRIHS FUNERAL HOME & CHAPEL  
410 WASHINGTON ROAD  
WESTMINSTER, MARYLAND 21157

22. Name and Address of Facility

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
a. MYELODYSPLASTIC SYNDROME  
Due to (or as a consequence of):  
b. PNEUMONIA  
Due to (or as a consequence of):  
c. SEPSIS  
Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death  
1 week  
1 week  
2 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier  
DAN H. SCHNEIDBERG MD

29c. License number  
D28221

29d. Date signed (Month, Day, Year)  
MAY 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
DAN H SCHNEIDBERG MD CARROLL COUNTY GENERAL HOSPITAL

31. Date filed (Month, Day, Year)  
MAY 05 1999

32. Registrar's Signature  
B. Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16012

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>MARY JANE KEEN</b>		2. Date of Death Month <b>May</b> Day <b>6</b> Year <b>1999</b>		3. Time of Death <b>0253</b>
4a. Facility Name (If not institution, give street and number) <b>507 West Central Avenue</b>		4b. City, Town, or Location of Death <b>Federalsburg</b>		4c. County of Death <b>Caroline</b>
5. Social Security Number <b>218-20-2668</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>10/11/26</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>Caroline</b>	10c. City, Town or Location <b>Federalsburg</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>507 West Central Avenue</b>		10f. Zip Code <b>21632</b>		10g. Citizen of What Country? <b>United States</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Processor</b>		16b. Kind of Business/Industry <b>Poultry</b>		
17. Father's Name (First, Middle, Last) <b>Albert Andrew</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Myrtle Carrie Handy</b>		
19a. Informant's Name/Relationship (Type, Print) <b>William Fluharty/Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>507 W. Central Ave., Federalsburg, MD 21632</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hill Crest Cemetery</b>		20c. Location - City or Town, State <b>5/9/99 Federalsburg, MD</b>
21. Signature of Funeral Service Licensee <b>Michael F. Eskow</b>		22. Name and Address of Facility <b>Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cryptogenic Cirrhosis</b> Due to (or as a consequence of): <b>b. Chronic Dehydrated state</b> Due to (or as a consequence of): <b>c. Compression Fractures of spine</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>10/10</b> <b>6 mo</b> <b>3 mo</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Suspected Carcinoma of Pancreas</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Michael F. Eskow</b>		29c. License number <b>D26388</b>		29d. Date signed (Month, Day, Year) <b>5-7-99</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael Fadden MD 302 Collins Harlock MD 21645</b>				
31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>		32. Registrar's Signature <b>Denise B. Sparks</b>		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 Edls  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





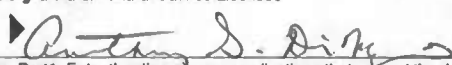

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16013

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUISE LOVEJOY				2. Date of Death Month Day Year APRIL 28, 1999		3. Time of Death 9:37 P.M.		
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 098-09-1890		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 18, 1906		
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State NY		10b. County KINGS		10c. City, Town or Location BROOKLYN		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 245 DEVOE STREET		10f. Zip Code 11211		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME					
17. Father's Name (First, Middle, Last) RUGGIERO D. RUGGIERO		18. Mother's Name (First, Middle, Maiden Surname) ANGELINA SORRENTINA		19a. Informant's Name/Relationship (Type, Print) DOLORES SENESE/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 245 DEVOE ST. BROOKLYN, NEW YORK 11211			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOHN'S CEMETERY		20c. Location - City or Town, State MIDDLE VILLAGE, NY		20d. Date 5/3/99			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATION PNEUMONIA Due to (or as a consequence of):  b. CEREBROVASCULAR DISEASE Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 24 HOURS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 41931		29d. Date signed (Month, Day, Year) APRIL 30, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. SHUMACHER, M.D. 2309 SHOREFIELD ROAD WHEATON, MARYLAND 20902		31. Data filed (Month, Day, Year) MAY 06 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16014

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) YOUNG KYUNG LEE				2. Date of Death Month Day Year Apr 29 1999		3. Time of Death 06:00pm	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 112-78-9729		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 25, 1965		9. Birthplace (State or Foreign Country) KOREA
	Usual Residence of Decedent							
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 263 CONGRESSIONAL LANE #312				10f. Zip Code 20852		10g. Citizen of What Country? KOREA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: ASIAN	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RESEARCH FELLOW			16b. Kind of Business/Industry EDUCATION	
17. Father's Name (First, Middle, Last) CHANG HA LEE				18. Mother's Name (First, Middle, Maiden Sumama) WOO WHA KWON				
19a. Informant's Name/Relationship (Type, Print) MYUNGSIK YOO/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 263 CONGRESSIONAL LANE #312 ROCKVILLE, MARYLAND 20852				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CREMATORY		20c. Date 5/3/99		20d. Location - City or Town, State BRENTWOOD, MARYLAND		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904				
23. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. Cardio pulmonary failure					Acute	
		Due to (or as a consequence of):						
		b. Stroke					Acute	
		Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. Advanced Gastric Cancer					Chronic	
		Due to (or as a consequence of):						
		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Wallmark M.D.						
		29c. License number MD51377		29d. Date signed (Month, Day, Year) April 30, 1999				
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) John Wallmark M.D. 9707 Mockingbird Lane, Rockville M.D. 20879								
31. Date filed (Month, Day, Year) MAY 03 1999		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16015

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name (First, Middle, Last) <i>Marjorie McDonald Little</i>				2. Date of Death Month <i>May</i> Day <i>2</i> Year <i>1999</i>		3. Time of Death <i>2235</i>	
4a. Facility Name (If not institution, give street and number) <i>3512 Peartree Ct. Apt 13</i>				4b. City, Town, or Location of Death <i>Silver Spring</i>		4c. County of Death <i>Montgomery</i>	
5. Social Security Number <i>579-18-7576</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>82</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>JAN. 23, 1917</i>	
9. Birthplace (State or Foreign Country) <i>VERMONT</i>		10a. State <i>MD</i>		10b. County <i>MONTGOMERY</i>		10c. City, Town or Location <i>SILVER SPRING</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>3512 PEARTREE COURT #13</i>		10f. Zip Code <i>20906</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <i>WHITE</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOME MAKER</i>		15b. Kind of Business/Industry <i>OWN HOME</i>		16. Decedent's Usual Occupation (Specify only highest grade completed) Collage (1-4 or 5+) <i>4</i>	
17. Father's Name (First, Middle, Last) <i>ALBERT EUGENE TUCKER</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>RUBY HAZEL McLAUGHLIN</i>			
19a. Informant's Name/Relationship (Type, Print) <i>LEONARD LITTLE (SON)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>801 N. PITTS ST. #304 ALEXANDRIA, VA 22314</i>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>CHESAPEAKE CREMATORY</i>		20c. Location - City or Town, State <i>5-4-99 BELTSVILLE, MD</i>		20d. Date	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. myocardial infarction</i> Due to (or as a consequence of): <i>DMF</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d.</i>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>John Brecher MD ME</i>		29c. License number <i>1000428</i>		29d. Date signed (Month, Day, Year) <i>May 2, 1999</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>IRR N. BRECHER MD ME Silver Spring, MD 20902</i>							
31. Date filed (Month, Day, Year) <i>MAY 04 1999</i>				32. Registrar's Signature <i>[Signature]</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16016

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fairfax Lomack

2. Date of Death

05 02 99

3. Time of Death

8:40 PM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

577-60-0256

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 19, 1901

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

700 Gallatin Street N.W.

10f. Zip Code

20011

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cartographer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Fielder Greene

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Burnside

19a. Informant's Name/Relationship (Type, Print)

Ernest E. Ross, cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

534 Pinedale Drive, Annapolis, Maryland 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Mem.Pk.

Date

5/7/99

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia  
Due to (or as a consequence of):

b. Gastrointestinal Bleed  
Due to (or as a consequence of):

c. Anemia  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 week

6 months

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

025430

29d. Date signed (Month, Day, Year)

05/03/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Tina MARGOLIS, MD 13952 Baltimore Ave Laurel MD 20707

31. Date filed (Month, Day, Year)

MAY 06 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16017

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER LUPISH</b>				2. Date of Death Month Day Year <b>MAY 05 1999</b>				3. Time of Death <b>5:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BERLIN NURSING HOME</b>				4b. City, Town, or Location of Death <b>BERLIN</b>				4c. County of Death <b>WORCESTER</b>	
Funeral Director	5. Social Security Number <b>112-05-2858</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04-24-1917</b>		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>	
	Usual Residence of Decedent									
10a. State <b>DELAWARE</b>		10b. County <b>SUSSEX</b>		10c. City, Town or Location <b>LEWES</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1508 HIGHWAY ONE</b>				10f. Zip Code <b>19958</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RESTAURANT OWNER</b>				16b. Kind of Business/Industry <b>FOOD</b>		
17. Father's Name (First, Middle, Last) <b>PHILLIP LUPISH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>IRENE M.N. UNKNOWN</b>						
19a. Informant's Name/Relationship (Type, Print) <b>SARAH DILLION/ FRIEND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1508 HIGHWAY ONE, LEWES, DELAWARE. 19958</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CONLEY'S CHAPEL CEMETERY</b>		Date <b>05-07-99</b>		20c. Location - City or Town, State <b>ANGOLA, DELAWARE</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>MELSON FUNERAL SERVICES, LTD. LONG NECK RD., MILLSBORO, DELAWARE. 19966</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. End Stage Parkinson's Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>f. Arteriosclerotic Cardiovascular Disease</b> <b>g. Thrombocytopenia</b> Due to (or as a consequence of):  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>h. Arteriosclerotic Cardiovascular Disease</b> <b>i. Thrombocytopenia</b>								Approximate Interval Between Onset and Death <b>5 yrs</b>		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>D29505</b>		
29d. Date signed (Month, Day, Year) <b>05/07/1999</b>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>GREGORIO BELLOSO, MD 5302 CHINABERRY DR. SALISBURY MD 21801 410-341-6321</b>						
31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

10252

1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16018

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>KING COLLINS LEWIS</b>				2. Date of Death Month <b>5</b> Day <b>4</b> Year <b>99</b>		3. Time of Death <b>7:00 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>11615 Church St.</b>				4b. City, Town, or Location of Death <b>Showell</b>		4c. County of Death <b>Worcester</b>	
5. Social Security Number <b>218-16-6317</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>4/1/21</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Showell</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>11615 Church St.</b>		10f. Zip Code <b>21862</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Grocery Store</b>		17. Father's Name (First, Middle, Last) <b>King Lewis</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Ocea Emma Collins</b>		19a. Informant's Name/Relationship (Type, Print) <b>Eunice McCabe</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 Decatur St. Berlin, MD 21811</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Cemetery</b>		20c. Location - City or Town, State <b>Berlin, MD</b>		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Burbage Funeral Home 108 William St. Berlin, MD 21811</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardio - Pulmonary Arrest</b> Due to (or as a consequence of): b. <b>MASSIVE MI</b> Due to (or as a consequence of): c. <b>HYPERTENSION</b> Due to (or as a consequence of): d. <b>ATRIAL FIBRILLATION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number <b>D-28798</b>		29d. Date signed (Month, Day, Year) <b>5-4-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. LILAH C. GONZALEZ, 314 FRANKLIN AVE. STE. 104, BERLIN, MD 21811</b>							
31. Date filed (Month, Day, Year) <b>MAY 06 1999</b>				32. Registrar's Signature <i>[Signature]</i>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

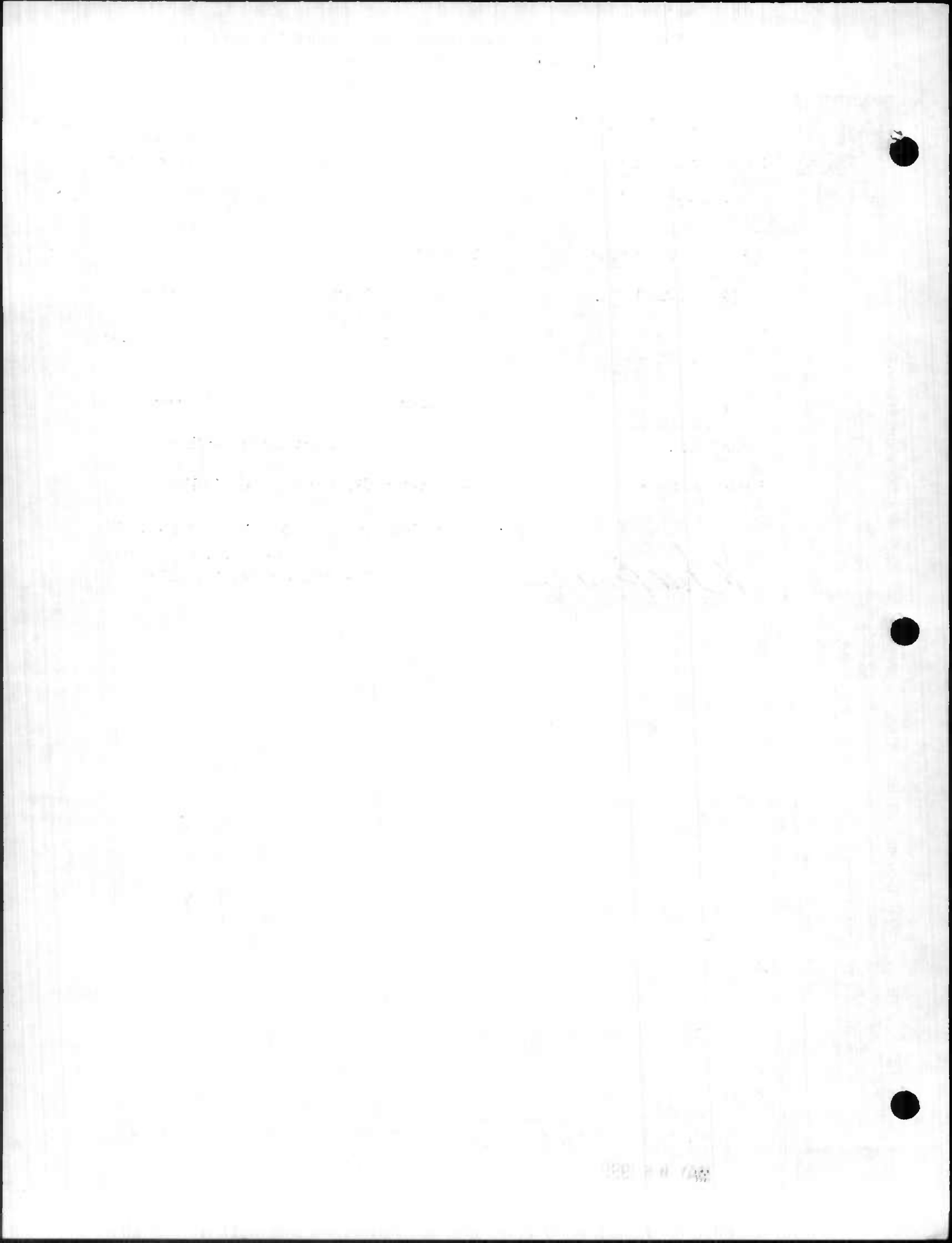
Baltimore, Maryland 21215-0020  
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



99-2418-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JESUS

State of Maryland / Department of Health and Mental Hygiene

MENDOZA ITEMS: #23 PART I, 27 PER MEO G771 5-19-99 WR. **Certificate of Death**

Reg. No.

99 16019

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jesus Mendoza</b>				2. Date of Death Month Day Year <b>APRIL 27, 1999</b>		3. Time of Death <b>11:40A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>58 FEDERAL COURT</b>				4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>None</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>26</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 6, 1972</b>	9. Birthplace (State or Foreign Country) <b>Mexico</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>58 Federal Court</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>Mexico</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Mexican</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Mailing Service</b>		
17. Father's Name (First, Middle, Last) <b>UNKNOWN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maria Mendoza</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Laura Mendoza/Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9910 Locust Street, Glenndale, Maryland 20769</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>5/3/99 Alexandria, Virginia</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>SEIZURE DISORDER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>APRIL 28, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wayne D. Korb 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amend #9, 5/13/99, JW, Mont. Cty.

99 16020

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Burt McKibben

2. Date of Death  
Month Day Year

MAY

02

1999

3. Time of Death

3:03 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

281-44-5034

6. Sex

M F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 6, 1948

9. Birthplace (State or Foreign Country)

Virginia Ohio

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6915 Wick Lane

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1968

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Program Manager

16b. Kind of Business/Industry

Computer Systems

17. Father's Name (First, Middle, Last)

Burt McKibben

18. Mother's Name (First, Middle, Maiden Surname)

Alice Thompson

19a. Informant's Name/Relationship (Type, Print)

Cynthia D. McKibben (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6915 Wick Lane Rockville, Md. 20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

May 5,

1999

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock

Due to (or as a consequence of):

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Right ventricular failure

Due to (or as a consequence of):

Hours

c. Right ventricular infarct

Due to (or as a consequence of):

Hours

d. Coronary artery disease

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status post coronary bypass

Spasm of radial artery graft to posterior descending artery

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Thomas M. Militano MD

29c. License number

D36207

29d. Date signed (Month, Day, Year)

May 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. THOMAS MILITANO 7610 CARROLL AVE TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16021

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Ernest J. Morrison

2. Date of Death

Month Day Year  
April 29, 1999

3. Time of Death

2120

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

292-07-6178

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
September 17, 1913

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Ohio

10b. County

Lucas

10c. City, Town or Location

Toledo

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4253 Beverly Drive

10f. Zip Code

43614

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

Ernest McKnight Morrison

18. Mother's Name (First, Middle, Maiden Surname)

Alice Jean Yule

19a. Informant's Name/Relationship (Type, Print)

Sarah A. Morrison/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13421 Coachlamp Lane, Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ottawa Hills Memorial Park

Date

May 8, 1999

20c. Location - City or Town, State

Toledo, Ohio

21. Signature of Funeral Service Licensee

Michael A. Higgins M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastro-intestinal bleeding

Due to (or as a consequence of):

b. Proximal Ulcer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day  
2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Leon Wang, M.D.

29c. License number

045880

29d. Date signed (Month, Day, Year)

4/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leon Wang, M.D., 10400 Connecticut Avenue #606, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Morrison, Ernest 4/29/99 02120000  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16022

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Loretta Bright Mosley</b>				2. Date of Death Month Day Year <b>April 30, 1999</b>				3. Time of Death <b>11:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Manor Care-Silver Spring</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>225-28-1500</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 7, 1911</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>15 West Lenox Street</b>				10f. Zip Code <b>20815</b>				10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeper</b>				16b. Kind of Business/Industry <b>Private Home</b>		
17. Father's Name (First, Middle, Last) <b>James H. Bright</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucy A. (not available)</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Robert H. Myers/Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 West Lenox Street, Chevy Chase, Maryland 20815</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		Date <b>May 2, 1999</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		
21. Signature of Funeral Service Licensee  <b>MO1126</b>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Stroke</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): <b>c. Dementia</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>1 Day</b> <b>10 Years</b> <b>10 Years</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number <b>D43237</b>				29d. Date signed (Month, Day, Year) <b>April 30, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Armstrong, M.D. 14201 Laurel Park Drive #102, Laurel, Maryland 20707-5298</b>										
31. Date filed (Month, Day, Year) <b>MAY 03 1999</b>				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amend #26, 5/4/99, PMW, Montg. Co.

99 16023

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MICHAEL F. MARCELLINO, SR.

2. Date of Death

Month Day Year  
APRIL 28, 1999

3. Time of Death

8:00PM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

578-12-9117

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 11, 1918

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3310 N.LEISURE WORLD BLVD. APT.118

10f. Zip Code

20906

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

STREET ENGINEER

16b. Kind of Business/Industry

D.C. GOVERNMENT

17. Father's Name (First, Middle, Last)

MICHAEL MARCELLINO

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE GUIFFRE

19e. Informant's Name/Relationship (Type, Print)

VICTORIA MARCELLINO/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3310 N.LEISURE WORLD BLVD. SILVER SPRING, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GATE OF HEAVEN

Date

5/3/99

20c. Location - City or Town, State

SILVER SPRING, MD

21. Signature of Funeral Service Licensee

Antony S. DiM...

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Hypoxemic Respiratory Failure  
Due to (or as a consequence of):  
Lung CancerApproximate  
Interval Between  
Onset and Death

6 months

6 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
N/A28b. Time of  
Injury

N/A

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

N/A

29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. B. Magliaro MD

29c. License number

D51908

29d. Date signed (Month, Day, Year)

4/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. B. Magliaro MD Montgomery General Hospital Prince Phillip Drive Olney MD

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16024

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Aster Maru

2. Date of Death

May 7, 1999

3. Time of Death

5:15 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-11-8702

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

55

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 23, 1943

9. Birthplace (State or Foreign Country)

Ethiopia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

11235 Oak Wood Drive

10f. Zip Code

20901

10g. Citizen of What Country?

Ethiopia

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Administration

17. Father's Name (First, Middle, Last)

Maru Gatew

18. Mother's Name (First, Middle, Maiden Surname)

Fantaye Abegaze

19a. Informant's Name/Relationship (Type, Print)

Yohannes Mesfin (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11235 Oak Wood Drive Silver Spring, Maryland 20901

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. John Cemetery

Date

05/10/99

20c. Location - City or Town, State

Addis Ababa, Ethiopia

21. Signature of Funeral Service Licensee

James S. Daley

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic colon cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

&gt; 1 yr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Colon cancer

Due to (or as a consequence of):

4 yrs

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Small bowel obstruction

Colon obstruction

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending  
investigation  
☐ Accident 6 ☐ Could not be  
determined  
☐ Suicide  
☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda M. Bunnell, MD

29c. License number

D35996

29d. Date signed (Month, Day, Year)

05-07-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Bunnell, MD, 2101 Medical Park Dr #210, Silver Spring, MD

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16025

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne Claire McKenna				2. Date of Death Month Day Year April 29, 1999		3. Time of Death 3:55 AM	
	4a. Facility Name (If not institution, give street and number) Manor Care				4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 129-24-8501		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) April 3, 1909	
	9. Birthplace (State or Foreign Country) New York		10a. State Md.		10b. County Montgomery		10c. City, Town or Location Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 5901 Cobalt Road		10f. Zip Code 20816	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry U.S. Army			
	17. Father's Name (First, Middle, Last) Thomas Egan				18. Mother's Name (First, Middle, Maiden Surname) Mary Murphy			
	19a. Informant's Name/Relationship (Type, Print) Ann Mehlbaum/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5901 Cobalt Rd., Bethesda, Maryland 20816			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State May 3, 99 Alexandria, Va.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W., Washington, D.C. 20007			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. cerebrovascular accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 1 week			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. depression, atrial fibrillation				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 				29c. License number D0038781		29d. Date signed (Month, Day, Year) April 30, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4910 Massachusetts Ave., N.W., Washington, D.C. 20016				31. Date filed (Month, Day, Year) MAY 03 1999				
32. Registrar's Signature 				State Registrar				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-16026

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William Matthews</i>				2. Date of Death Month <i>May</i> Day <i>01</i> Year <i>1999</i>				3. Time of Death <i>17:11</i>	
	4a. Facility Name (If not institution, give street and number) <i>Sinai Hospital Baltimore</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death	
Funeral Director	5. Social Security Number <i>213-12-6682</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>75</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>06/09/1923</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent				10a. State <i>MD</i>		10b. County <i>Carroll</i>		10c. City, Town or Location <i>Hampstead</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <i>1148 South Main Street</i>				10f. Zip Code <i>21074</i>	
	10g. Citizen of What Country? <i>USA</i>				11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Title and Tag work</i>				16b. Kind of Business/Industry <i>Auto Tag &amp; Title</i>				17. Father's Name (First, Middle, Last) <i>Arthur J. Matthews</i>	
	18. Mother's Name (First, Middle, Maiden Summa) <i>Gladys Bishop</i>				19a. Informant's Name/Relationship (Type, Print) <i>John W. Matthews Son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3105 Warehime Rd. Manchester MD 21102</i>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Hampstead Cemetery</i>				20c. Location - City or Town, State <i>05/05/99 Hampstead MD</i>	
	21. Signature of Funeral Service Licensee <i>Steven W. Elme</i>				22. Name and Address of Facility <i>Eline Funeral Home</i> <i>934 South Main St Hampstead MD 21074</i>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Sepsis</i> Due to (or as a consequence of): b. <i>Status post Coronary artery bypass graft</i> Due to (or as a consequence of): c. <i>Coronary Artery disease</i> Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier <i>Amador Subong</i>				29c. License number <i>Res-000</i>				29d. Date signed (Month, Day, Year) <i>May 01, 1999</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Amador Subong 2401 W. Belvedere Avenue, Baltimore, Maryland 21215</i>				31. Date filed (Month, Day, Year) <i>MAY 04 1999</i>				32. Registrar's Signature <i>Anna G. Sparks</i>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 16027

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) SUSAN FOWLER MOYER  
2. Date of Death Month Day Year MAY 6, 1999  
3. Time of Death 3:01 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number) CIVISTA MEDICAL CENTER  
4b. City, Town, or Location of Death LAPLATA  
4c. County of Death CHARLES

5. Social Security Number 245-70-8839  
6. Sex ☐ M ☒ F  
7. Age (In yrs. last birthday) 52 Yrs.  
8. Date of Birth (Month, Day, Year) March 12, 1947  
9. Birthplace (State or Foreign Country) North Carolina

Usual Residence of Decedent

10a. State MD  
10b. County Charles  
10c. City, Town or Location La Plata  
10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 9905 Beech Lane  
10f. Zip Code 20646  
10g. Citizen of What Country? USA

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 6  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Media Relations Communications  
16b. Kind of Business/Industry Pepco

17. Father's Name (First, Middle, Last) Arthur Werner Fowler  
18. Mother's Name (First, Middle, Maiden Sumama) Pearl Hoover Fowler

19a. Informant's Name/Relationship (Type, Print) John E. Moyer/Husband  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 506 La Plata, MD 20646

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory  
20c. Location - City or Town, State 5/7/99 Alexandria, VA

21. Signature of Funeral Service Licensee [Signature] M00174  
22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME P.A. P.O. BOX 567 LA PLATA MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) e. Metastatic Adenocarcinoma of the Lung 1 year

Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

25. Was case referred to medical examiner? ☐ Yes ☒ No  
26. Place of Death (Check only one) Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? ☐ Yes ☒ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

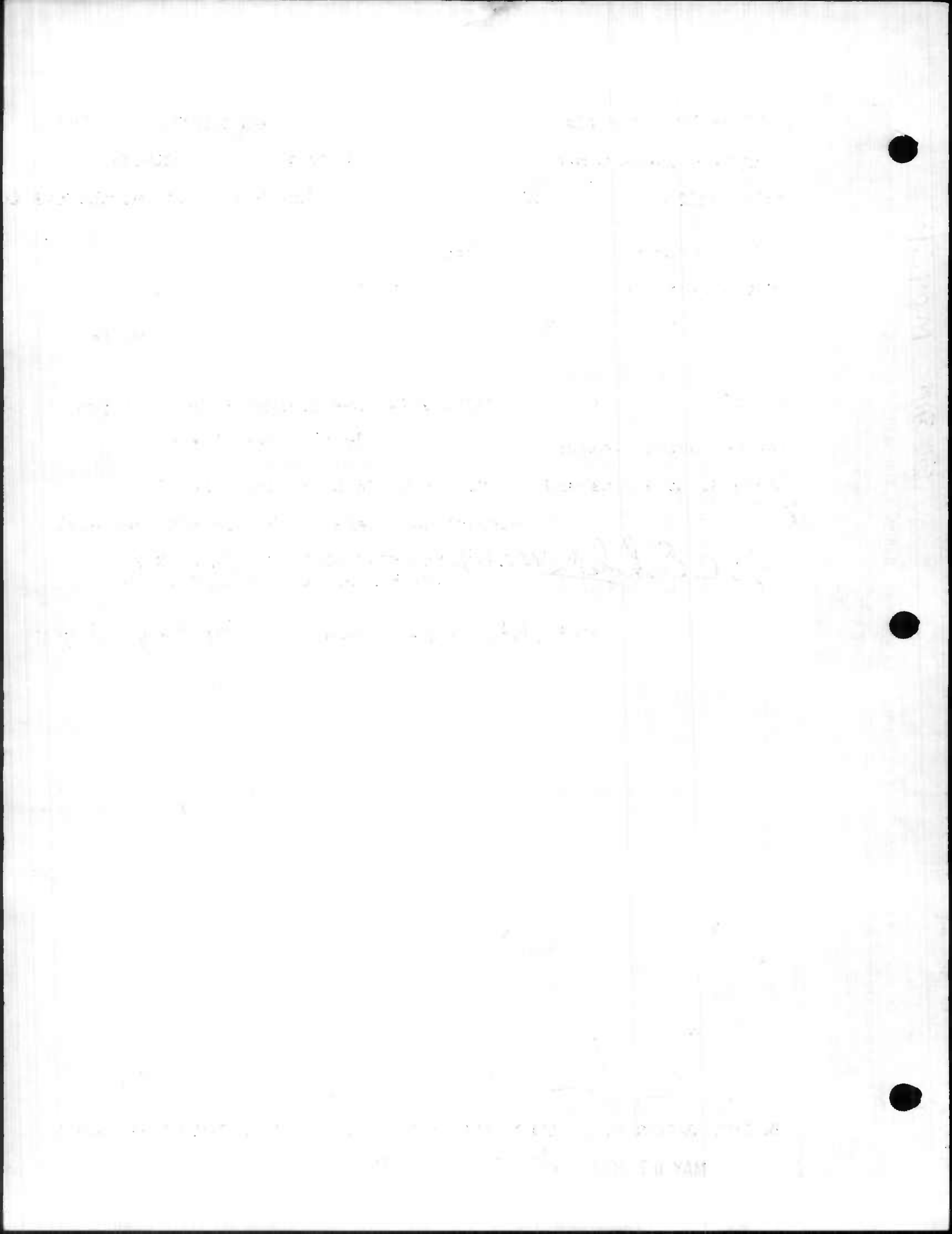
29b. Signature and title of certifier [Signature] MD  
29c. License number D-33426  
29d. Date signed (Month, Day, Year) 5/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. LARRY JENKINS M.D. 111 LAGRANGE AVENUE P.O. BOX 1724 LAPLATA MD. 20646

31. Date filed (Month, Day, Year) MAY 07 1999  
32. Registrar's Signature [Signature]

State  
Registrar

SUSAN MOYER  
Baltimore, Maryland 21215-0020  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  
To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16028

ITEMS: #25 PER MD G771 5-18-99 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irene J. Mouldsdales</b>				2. Date of Death Month <b>May</b> Day <b>2</b> Year <b>1999</b>		3. Time of Death <b>18:09</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-28-5405</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 28, 1915</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>922 S. DECKER AVE.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>U.S.A.</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTODIAN</b>		16b. Kind of Business/Industry <b>SCHOOL</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>BRYANT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>KATHERINE KLIEN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>CARLINA WILLIAMS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6832 CORNELL RD. BALTO. MD. 21220</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OAK LAWN CEM.</b>		Date <b>MAY 6 1999</b>		20c. Location - City or Town, State <b>BALTO. CO. MD.</b>	
	21. Signature of Funeral Service Licensee <b>Thomas J. Akanda Jr.</b>		22. Name and Address of Facility <b>HOFFMAN - SKARDA FH</b>		3218 HUDSON ST. <b>BALTO. MD. 21224</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ventricular fibrillation</b> Due to (or as a consequence of): <b>b. Persistent bradycardia</b> Due to (or as a consequence of): <b>c. Right cerebral stroke; cardioembolic</b> Due to (or as a consequence of): <b>d. Atrial fibrillation</b>							Approximate Interval Between Onset and Death <b>1 minute</b> <b>12 hours</b> <b>5 days</b> <b>20 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease - ventilator dependent</b> <b>Hypertension</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Irene Dankwa MD</b>		29c. License number <b>JHB 97012</b>		29d. Date signed (Month, Day, Year) <b>May 2nd 1999</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Irene Dankwa, Johns Hopkins Bayview Medical Center, Baltimore, Maryland</b>								
31. Date filed (Month, Day, Year) <b>MAY 18 1999</b>		32. Registrar's Signature <b>Irene J. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

CM AMEND ITEMS: #23 PART I, 27, 28D G77's 7-28-99 WR

Unknown 99-090 ROBERT MCCARTHY

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-28-99 WR. Certificate of Death

Reg. No.

99 16029

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert John McCarthy				2. Date of Death Month Day Year May 04, 1999				3. Time of Death 1:32 P.M.				
	4e. Facility Name (If not institution, give street and number) C & D Canal near Army Corps of Engineers				4b. City, Town, or Location of Death Chesapeake City				4c. County of Death Cecil				
Funeral Director	5. Social Security Number 219-80-0779		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 33 Yrs.		8. Date of Birth (Month, Day, Year) June 2, 1965		9. Birthplace (State or Foreign Country) Pennsylvania				
	Usual Residence of Decedent												
10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10a. Street and Number 610 Elkton Boulevard				10f. Zip Code 21921				10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-employed Master Electrician				16b. Kind of Business/Industry Electric					
17. Father's Name (First, Middle, Last) John E. McCarthy						18. Mother's Name (First, Middle, Maiden Surname) Geraldine C. Ryan							
19a. Informant's Name/Relationship (Type, Print) Geraldine C. McCarthy/Mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Elkton Boulevard, Elkton, Maryland 21921							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Immaculate Conception Cemetery		Date 5/8/99		20c. Location - City or Town, State Cherry Hill, Maryland					
21. Signature of Funeral Service Licensee Donald S. Hicks						22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 West Stockton Street, Elkton, Maryland 21921							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HEAD INJURIES, COCAINE INTOXICATION AND SUBMERSION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Found: May 4, 1999		28b. Time of Injury Found: 11:00		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN SUBJECT STRUCK AND CUT			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RIVER				28f. Location (Street and Number or Rural Route Number, City or Town, State) C AND CANAL NEAR ARMY CORPS OF ENGINEERS, CHESAPEAKE CITY, MD					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier Theodore M. King						29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) May 05, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201													
31. Date filed (Month, Day, Year) MAY 18 1999				32. Registrar's Signature B. Sparks									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16030

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES FULTON McNEW				2. Date of Death Month Day Year May 5 1999		3. Time of Death 1634
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot
Funeral Director	5. Social Security Number 225-44-5578	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 13 1930	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Dorchester	10c. City, Town or Location Madison		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1309 Taylors Island Rd.		10f. Zip Code 21648		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1948-52		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) master mechanic		16b. Kind of Business/Industry steel mfg		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frank McNew				18. Mother's Name (First, Middle, Maiden Surname) Edgar Alice Moore		
	19a. Informant's Name/Relationship (Type, Print) Patsy S. McNew - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Taylors Island Rd., Madison MD 21648		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 5-10		20c. Location - City or Town, State Hurlock, Maryland		
	21. Signature of Funeral Service Licensee Kenneth R. Thomas		22. Name and Address of Facility Thomas Funeral Home PA 700 Locust St. Cambridge MD 21613				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Aspiration and hypotension Due to (or as a consequence of): c. Bowel Perforation Due to (or as a consequence of): d. T-Cell Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 8 hrs
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) as stated.		29b. Signature and title of certifier Susan T. Forlifer MD		29c. License number ME D06804	29d. Date signed (Month, Day, Year) 5-5-99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan T. Forlifer MD 505 Dutchmans Lane Easton MD 21601						
	31. Date filed (Month, Day, Year) MAY 07 1999		32. Registrar's Signature B. Sparks				

James McNew 21215-0020  
Baltimore, Maryland 21215-0020  
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16031

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John V. Neri

2. Date of Death

Month

Day

Year

May 5, 1999

3. Time of Death

11:20 PM

4a. Facility Name (If not institution, give street and number)

Crescent Cities Adult Medical Day Center

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-09-2434

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Dec. 24, 1909

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1914 Upshur Street, N.E.

10f. Zip Code

20018

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Store Manager

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Guiseppe Neri

18. Mother's Name (First, Middle, Maiden Surname)

Caterina Murabito

19a. Informant's Name/Relationship (Type, Print)

Robert Neri (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5705 Nevada Street Berwyn Heights, Maryland 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

5/8/99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetic Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

325071

29d. Date signed (Month, Day, Year)

5/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. W. Hollander, no 7404 Executive Place, #502, Bethesda, MD 20904

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16032

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold Philip Nesbitt, Sr.					2. Date of Death Month Day Year April 30, 1999			3. Time of Death 7:50 am	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital					4b. City, Town, or Location of Death Silver Spring			4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-16-5906		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) April 1, 1922		9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Montgomery		10c. City, Town or Location Kensington	
Usual Residence of Decedent										
10a. State MD		10b. County Montgomery		10c. City, Town or Location Kensington				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 10231 Carroll Place					10f. Zip Code 20895			10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer			16b. Kind of Business/Industry Self-Employed		
17. Father's Name (First, Middle, Last) Harold Hyman Nesbitt					18. Mother's Name (First, Middle, Maiden Surname) Theresa A. Unknown					
19a. Informant's Name/Relationship (Type, Print) H. Philip Nesbitt, Jr. / son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3121 Cobb Hill Lane, Oakton, VA 22124					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory			Date 5/1/99		20c. Location - City or Town, State Alexandria, VA		
21. Signature of Funeral Service Licensee Eric S. Scerbo					22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd, West, Silver Spring, MD 20901					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic coronary vascular disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Jeanne P. Asner					29c. License number D34034			29d. Date signed (Month, Day, Year) 4/30/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEANNE P. ASNER, MD 3720 FARRAGUT AVE, KENSINGTON MD 20895										
31. Date filed (Month, Day, Year) MAY 03 1999					32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5 x 1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16033

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Amelia G. Porro</b>				2. Date of Death Month Day Year <b>May 2, 1999</b>		3. Time of Death <b>6:15PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Bethesda</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>579-70-1579</b>	8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 4, 1910</b>	9. Birthplace (State or Foreign Country) <b>Cuba</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>5729 Bradley Boulevard</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>Cuban</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Hispanic</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Enrique Garcia</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Manuela Perez</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Bertha M. Lastre/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18764 Olney Mill Road Olney, Maryland 20832</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Mausoleum</b>		Date <b>May 5, 1999</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert A. Humphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Respiratory Arrest</b> Due to (or as a consequence of):  b. <b>Advanced Spinal Stenosis</b> Due to (or as a consequence of):  c. <b>Malnutrition</b> Due to (or as a consequence of):  d. <b>Anemia</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death  <b>Sudden</b>  <b>10 Years</b>  <b>2 Years</b>  <b>2 Years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Intractable Pain Secondary Spinal Stenosis</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D20065</b>		29d. Date signed (Month, Day, Year) <b>May 3, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Eva M. Morell, M.D. 6000 Executive Boulevard #300 Rockville, Maryland 20852-3803</b>							
31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16034

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ella Fern Haskell Poliquin

2. Date of Death

Month Day Year

May 1, 1999

3. Time of Death

12:45 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

322-09-4628

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 9, 1901

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4521 East West Highway

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Edward Haskell

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Guyette

19a. Informant's Name/Relationship (Type, Print)

Rebecca C. Harmon/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3555 Raymoor Road, Kensington, Maryland 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

May 4, 1999

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

MO1126

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of)

years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Subdural hematoma

Due to (or as a consequence of)

days

c. Closed head injury

Due to (or as a consequence of)

days

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

April 24, 1999

28b. Time of Injury

4:00 P.M.

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fall

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4521 East West Highway, #208 Bethesda, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patricia L. Tomsko, MD

29c. License number

D51916

29d. Date signed (Month, Day, Year)

May 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia L. Tomsko, MD, 11440 Rockville Pike, #348, Rockville, MD 20852

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

20





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16035

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phoebe G. Purdy						2. Date of Death Month Day Year May 6 1999		3. Time of Death 12:33 AM																																																
	4a. Facility Name (If not institution, give street and number) HCR Manor Care Chevy Chase						4b. City, Town, or Location of Death Chevy Chase		4c. County of Death Montgomery																																																
Funeral Director	5. Social Security Number 145-09-3084		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 28, 1911		9. Birthplace (State or Foreign Country) NY																																																
	Usual Residence of Decedent																																																								
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Olney				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																																
	10e. Street and Number 17305 Guttenberg Court				10f. Zip Code 20832		10g. Citizen of What Country? USA																																																		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																																																	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Education																																																		
	17. Father's Name (First, Middle, Last) Harry A. Griffith						18. Mother's Name (First, Middle, Maiden Surname) Anna K. Mendyk																																																		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Ellen Meng / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17305 Guttenberg Court, Olney, Maryland 20832																																																				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Date 5/8/1999		20d. Location - City or Town, State Silver Spring, Maryland																																																		
	21. Signature of Funeral Service Licensee William L. B...				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. W., Silver Spring MD 20901																																																				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																								
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">e. Aspiration Pneumonia</td> <td>3 Days</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Stroke</td> <td colspan="8">b. Due to (or as a consequence of):</td> <td>10 Years</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="2"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	e. Aspiration Pneumonia								3 Days	Due to (or as a consequence of):									Stroke	b. Due to (or as a consequence of):								10 Years	Due to (or as a consequence of):									Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Immediate Cause (Final disease or condition resulting in death)	e. Aspiration Pneumonia								3 Days																																																
	Due to (or as a consequence of):																																																								
	Stroke	b. Due to (or as a consequence of):								10 Years																																															
		Due to (or as a consequence of):																																																							
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																																									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																																									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																																									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																																									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																																									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																																									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																																																									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred																																																	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																																			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																																									
29b. Signature and title of certifier Kevin G. Nealon M.D.				29c. License number D23127		29d. Date signed (Month, Day, Year) May 6, 1999																																																			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kevin G. Nealon, M.D. 5530 Wisconsin Ave. #925, Chevy Chase, Maryland 20815																																																									
31. Date filed (Month, Day, Year) MAY 07 1999		32. Registrar's Signature B. Sparks																																																							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

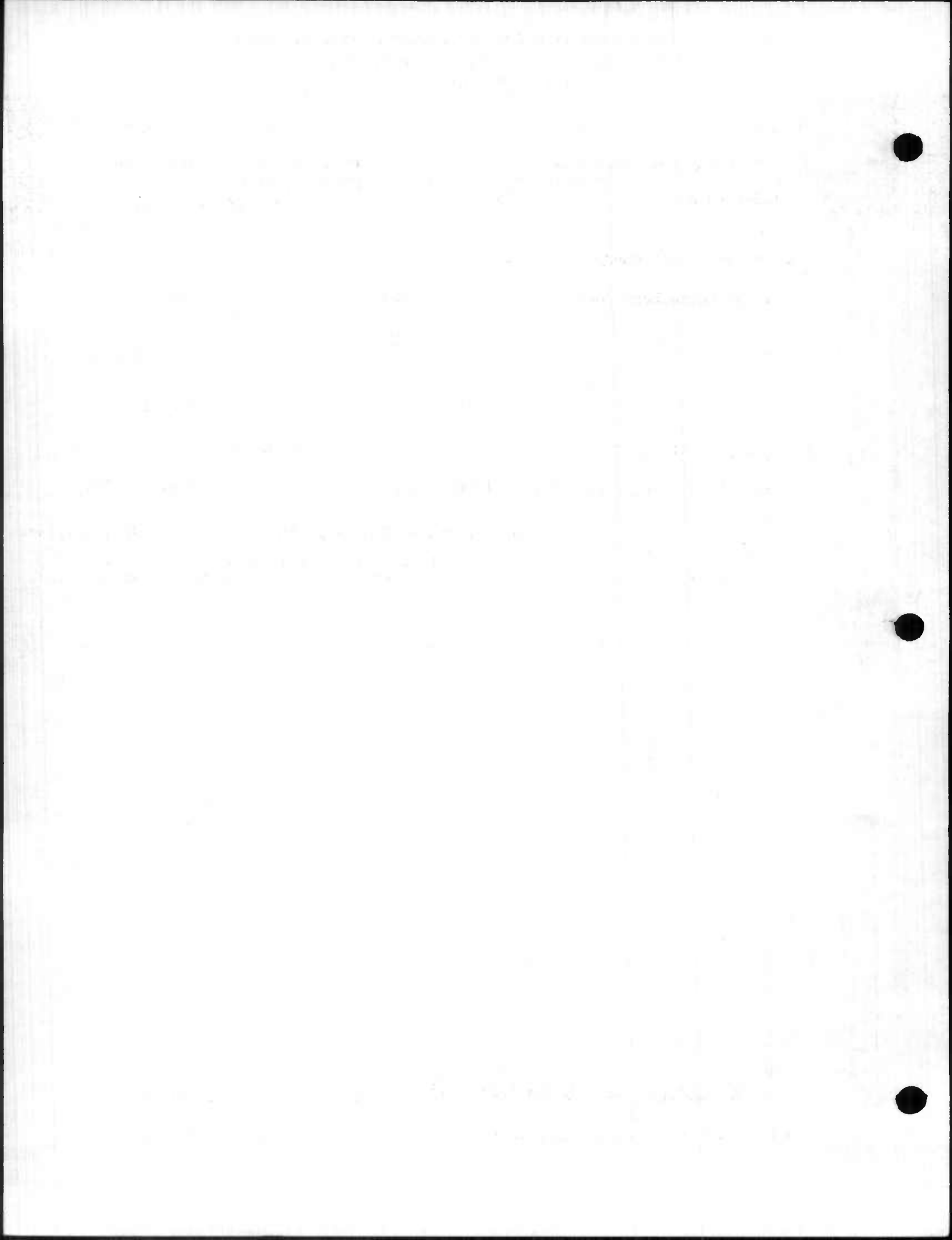
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16036

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **GLADYS ELIZABETH PHILLIPS** 2. Date of Death Month **May** Day **01** Year **1999** 3. Time of Death **3:40 pm**

4a. Facility Name (If not institution, give street and number) **Chesapeake Woods Center** 4b. City, Town, or Location of Death **Cambridge** 4c. County of Death **Dorchester**

Funeral  
Director

5. Social Security Number **219-36-7205** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **97** Yrs. 8. Date of Birth (Month, Day, Year) **Aug. 10 1901** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent

10a. State **MD** 10b. County **Dorchester** 10c. City, Town or Location **Cambridge** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **417 Maryland Ave.** 10f. Zip Code **21613** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **white**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **11** College (1-4 or 5+) **3** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **teacher** 16b. Kind of Business/Industry **public schools**

17. Father's Name (First, Middle, Last) **John Howard Phillips** 18. Mother's Name (First, Middle, Maiden Surname) **Sallie Delaha**

19a. Informant's Name/Relationship (Type, Print) **Mrs. Mary Ellen Clark-niece** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **1 Rolling Rd., Chestertown MD 21620**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Dorchester Memorial Park** Data **5-5-99** 20c. Location - City or Town, State **Cambridge, Maryland**

21. Signature of Funeral Service Licensee **Thomas Funeral Home, PA** 22. Name and Address of Facility **700 Locust St. Cambridge MD 21613**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) **a. CONGESTIVE HEART FAILURE** 1 day  
Due to (or as a consequence of):  
**b. ISCHEMIC HEART DISEASE** 1 YEAR  
Due to (or as a consequence of):  
**c. HYPERTENSION** YEARS  
Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **DIABETES MELLITUS - 2** 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Michael A. Moskewicz MD** 29c. License number **D-16609** 29d. Date signed (Month, Day, Year) **MAY 3, 1999**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **MICHAEL A. MOSKEWICZ MD. 503 BYRN ST. CAMBRIDGE, MD**

31. Date filed (Month, Day, Year) **MAY 04 1999** 32. Registrar's Signature **James S. Sparks** **21613**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020 **hcb**

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16037

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elsie Kane Pierson</b>						2. Date of Death Month Day Year <b>April 12, 1999</b>		3. Time of Death <b>10:55 a.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>26188 Three Notch Road</b>						4b. City, Town, or Location of Death <b>Mechanicsville</b>		4c. County of Death <b>St. Mary's</b>		
Funeral Director	5. Social Security Number <b>577-16-7379</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 28, 1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>D.C.</b>		10b. County		10c. City, Town or Location <b>Washington</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>4315 4th Street, N.W.</b>						10f. Zip Code <b>20011</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Data Processor</b>			16b. Kind of Business/Industry <b>U.S. Government</b>				
17. Father's Name (First, Middle, Last) <b>Samuel Kane</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Blanche Beal</b>					
19a. Informant's Name/Relationship (Type, Print) <b>William M. Gunn, Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>42502 Keith Court, Hollywood, Maryland 20636</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>		Date <b>4/16/99</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>			
21. Signature of Funeral Service Licensee <b>Mary B. Rizzo</b>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Md 20650</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Pneumonia</b> Due to (or as a consequence of): <b>b. Cerebellar Ataxia R. J.</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d. Anemia &amp; Dehydration</b>										Approximate Interval Between Onset and Death <b>10 days</b> <b>1997</b> <b>1 month</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia 1997</b> <b>RT Lower Leg Weakness 1997</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how Injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>R. Jhaveri</b>		29c. License number <b>D32651</b>		29d. Date signed (Month, Day, Year) <b>4/13/99</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Rita Jhaveri, M.D. 22335 Exploration Drive, Lexington Park, Maryland 20653</b>											
31. Date filed (Month, Day, Year) <b>APR 16 1999</b>				32. Registrar's Signature <b>Geneva S. Sparks</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16038

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louis. J. ROSENHEIM

2. Date of Death

May 4th 1999

3. Time of Death

9-19PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

220-05-4241

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 6, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

5363 Hesperus Drive

10f. Zip Code

21044

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Representative

16b. Kind of Business/Industry

Furniture &amp; Carpet

17. Father's Name (First, Middle, Last)

Louis Gustav Rosenheim

18. Mother's Name (First, Middle, Maiden Surname)

Estelle Hamburger

19a. Informant's Name/Relationship (Type, Print)

Philip L. Rosenheim (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

609 Fieldstone Road, Silver Spring, Maryland 20905

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

5-5-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

R. L. Rapp

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. DIABETES MELLITUS

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 days

2 weeks

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

N.B. Vellanki

29c. License number

D-30469

29d. Date signed (Month, Day, Year)

May 5th 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.B. VELLANKI, 9055, CHEVROLET DRIVE, # 100, ELLICOTT CITY, MD. 21042

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 06 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16039

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN WILLIAM RODGERS</b>				2. Date of Death Month <b>5</b> Day <b>3</b> Year <b>99</b>		3. Time of Death <b>2345</b>		
	4a. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>214-01-9993</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11/6/15</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean City</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>13707 N. Ocean RD</b>		10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Car Dealership</b>		17. Father's Name (First, Middle, Last) <b>John William Rodgers, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Von Mullenheim</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Viola Rodgers/ Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13707 N. Ocean RD Ocean City, MD 21842</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Burbage Funeral Home 108 William st. Berlin, MD 21811</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LUNG CANCER</b>		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23c. Were an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>046257</b>		29d. Date signed (Month, Day, Year) <b>5/4/99</b>		30. Name and address of person who completed cause of death (Item 28e) (Type, Print) <b>974 Healthway Drive Berlin, MD 21811</b>	
31. Date filed (Month, Day, Year) <b>MAY 06 1999</b>		32. Registrar's Signature 		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.	

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16040

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard R. Simpson

2. Date of Death

Month Day Year  
May 3, 1999

3. Time of Death

3:40AM

4a. Facility Name (If not institution, give street and number)

7605 Maple Avenue

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

569-20-9889

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 27, 1925

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7605 Maple Avenue

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Diplomat

16b. Kind of Business/Industry

United States  
Government

17. Father's Name (First, Middle, Last)

William Simpson

18. Mother's Name (First, Middle, Maiden Surname)

Columbia Profumo

19a. Informant's Name/Relationship (Type, Print)

Maggie Alice Simpson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4138 Leland Street, Chevy Chase, Maryland 20815

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)May 3, 1999  
Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

MO1126

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc., 7557 Wisconsin  
Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Renal Cell Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D43083

29d. Date signed (Month, Day, Year)

May 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Sotos, M.D. 10605 Concord Street, #300, Kensington, Maryland 20895-2594

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

George Sotos

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99-16041

Amend #7,5/5/99, BMW, Montg. Co

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) REVA SACKS				2. Date of Death Month Day Year MAY 3, 1999				3. Time of Death 7:20 AM		
	4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 159-07-7161		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 <del>89</del> Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 14, 1907		9. Birthplace (State or Foreign Country) PENNSYLVANIA		
	Usual Residence of Decedent										
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 6121 MONTROSE ROAD				10f. Zip Code 20852		10g. Citizen of What Country? UNITED STATES					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME			
17. Father's Name (First, Middle, Last) LOUIS COHEN				18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN)							
19a. Informant's Name/Relationship (Type, Print) MICHAEL SACKS (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1920 N STREET, NW - WASHINGTON, D.C. 20003							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MONTEFIORE CEMETERY		20c. Location - City or Town, State 5/6/99 PHILADELPHIA, PA.					
21. Signature of Funeral Service Licensee Donald C. Stottmeyer				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC CANCER TO PERITONIUM Due to (or as a consequence of): b. UNKNOWN PRIMARY CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
23c. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier D.D. Patel M.D.				29c. License number D18084				29d. Date signed (Month, Day, Year) MAY 03, 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) D.D. PATEL, M.D. 6121 MONTROSE RD, ROCKVILLE MD 20852											
31. Date filed (Month, Day, Year) MAY 05 1999				32. Registrar's Signature B. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>LEON SANDLER</b>		2. Date of Death Month Day Year <b>MAY 1, 1999</b>		3. Time of Death <b>12 NOON</b>	
4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>			4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>
5. Social Security Number <b>579-24-5160</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 4, 1904</b>
9. Birthplace (State or Foreign Country) <b>BESSARABIA</b>					
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>ROCKVILLE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6121 MONTROSE ROAD</b>		10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MERCHANT</b>		16b. Kind of Business/Industry <b>NEW &amp; USED FURNITURE</b>			
17. Father's Name (First, Middle, Last) <b>MAX SANDLER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>(UNKNOWN)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT M. SANDLER (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6216 YORKSHIRE TERRACE - BETHESDA, MARYLAND 20814</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. LEBANON CEMETERY</b>		20c. Location - City or Town, State <b>5/3/99 ADELPHI, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>Donald C. Stottmeyer</b>		22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CEREBRAL ISCHEMIA</b> Due to (or as a consequence of): <b>b. GENERALIZED ATHEROSCLEROSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CORONARY ARTERY DISEASE</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Steve Lipson MD</b>		29c. License number <b>D 05885</b>		29d. Date signed (Month, Day, Year) <b>05/01/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE</b>					
31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39 16043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILIP SCHONFELD		2. Date of Death Month 1 Day 1999 Year		3. Time of Death 9:50 AM
	4a. Facility Name (If not institution, give street and number) MANOR CARE		4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 091-03-5432	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	8. Date of Birth (Month, Day, Year) APRIL 27, 1902	9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State NEW JERSEY	10b. County MORRIS	10c. City, Town or Location MORRISTOWN		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 287 MT. KIMBLE AVENUE		10f. Zip Code 07960		10g. Citizen of What Country? UNITED STATES
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE		16b. Kind of Business/Industry GLASS PROCESSING
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) ALBERT SCHONFELD		18. Mother's Name (First, Middle, Maiden Surname) FANNIE DEUTSCH		
	19a. Informant's Name/Relationship (Type, Print) NORMAN J. SCHONFELD (SON)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 287 MT. KIMBLE AVE.-MORRISTOWN, NEW JERSEY 07960		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) B'NAI ABRAHAM MEM.PARK		20c. Location - City or Town, State UNION, NEW JERSEY
	21. Signature of Funeral Service Licensee <i>Donald C. Stumm</i>		22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852		
Physician /Medical Examiner	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <i>Cerebral Vascular Disease</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 5 yrs.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
			28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D095522		29d. Date signed (Month, Day, Year) 5/2/99
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Schonfeld MD 5530 Wisconsin Ave Chevy Chase MD 20815				
State Registrar	31. Date filed (Month, Day, Year) MAY 05 1999		32. Registrar's Signature <i>[Signature]</i>		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16045

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WAYNE CURTIS SELLERS				2. Date of Death Month Day Year May 03, 1999		3. Time of Death 12:46 A.M.		
	4a. Facility Name (If not institution, give street and number) Prince George's County Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 219-06-1323	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 30 Yrs.	8. Date of Birth (Month, Day, Year) OCT. 20, 1968	9. Birthplace (State or Foreign Country) WASH., D.C.				
	Usual Residence of Decedent								
10a. State MD		10b. County PRINCE GEORGE		10c. City, Town or Location FAIRMONT HEIGHTS		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 5710 K. STREET				10f. Zip Code 20748		10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PAINTER		16b. Kind of Business/Industry SELF EMPLOYED			
17. Father's Name (First, Middle, Last) WOODROW SELLERS				18. Mother's Name (First, Middle, Maiden Surname) ROSA MCRAE					
19a. Informant's Name/Relationship (Type, Print) ROSA SELLERS MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5116 DOPPLAR ST., CAPITOL HEIGHTS, MD. 20743					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK		Date 5/8/99		20c. Location - City or Town, State LANDOVER, MARYLAND			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W., WASH, DC. 20011					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>GUNSHOT WOUND OF ABDOMEN</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 5-2-99		28b. Time of Injury 10:18 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred SHOOT WDS SHOT.		28e. Location (Street and Number or Rural Route Number, City or Town, State) 5710 DOPPLAR ST PRINCE GEORGES CO MD					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) May 03, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAYNOR KOSCH 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 06 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16044

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRIETTA ADLER SCHWARTZ

2. Date of Death

Month Day Year  
MAY 3, 1999

3. Time of Death

12:45 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

215-46-0633

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 6, 1904

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (14 or 5+)  
12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ALBERT L. ADLER

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE LEVY

19a. Informant's Name/Relationship (Type, Print)

MARION KRASKIN (NIECE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4600 MASSACHUSETTS AVE., NW-WASHINGTON, D.C. 20016

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WASH. HEBREW CONG. MEM. PK. 5/6/99

Date

20c. Location - City or Town, State

WASHINGTON, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.  
1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Katharine R. Lillie MD

29c. License number

D53244

29d. Date signed (Month, Day, Year)

May 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katharine R. Lillie, MD 11140 Rockville Pike #348, Rockville, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

HENRIETTA A SCHWARTZ

12:43 AM 5/3/99  
Division of Vital Records, P.O. Box 68760,

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16046

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Myrtle F. Sharp

2. Date of Death  
Month Day Year  
May 3, 19993. Time of Death  
7:20 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-28-1631

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 17, 1905

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11118 Eascrest Drive

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Frank Parks

18. Mother's Name (First, Middle, Maiden Surname)

Serita Beasley

19a. Informant's Name/Relationship (Type, Print) (grand-  
daughter)  
Kelly J. Hatzipanagiotis19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
Same as 10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Data

5-5-99

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

▶ *Deann H. Rapp*

22. Name and Address of Facility

Rapp Funeral Services, P. A.  
933 Gist Avenue, Silver Spring, MD 2091023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Diffuse bronchopneumonia*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

3 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Demerol**Anorexia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Barry Rosenbaum, M.D.*

29c. License number

D09834

29d. Date signed (Month, Day, Year)

5/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON, MD - 20895

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

▶ *B. Sparks*

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16047

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE MARIE SPRAGUE

2. Date of Death

Month Day Year  
APRIL 28, 1999

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

16605 Winterwoods Ct

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

188-24-3111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 24, 1930

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16605 Winterwoods Ct

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter Machcoviak

18. Mother's Name (First, Middle, Maiden Surname)

Stella Nedza

19a. Informant's Name/Relationship (Type, Print)

Merle E. Sprague/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16605 Winterwoods Ct, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

May 3

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

▶ Alan J. Danell

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Rectal Cancer

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ Jon L. Hopkins

29c. License number

0101051742

29d. Date signed (Month, Day, Year)

April 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon L. Hopkins Walter Reed Army Medical Center Washington, DC 20307

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

Keneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16048

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Marian Stoakes

2. Date of Death

Month Day Year  
May 4, 1999

3. Time of Death

7:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

227 Grant Avenue

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

507-46-2257

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 23, 1903

9. Birthplace (State or Foreign Country)

North Dakota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

227 Grant Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Elementary School

17. Father's Name (First, Middle, Last)

Jas. A. Jeffries

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Webb

19a. Informant's Name/Relationship (Type, Print)

Carolyn Stoakes Larson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

227 Grant Avenue, Takoma Park, Maryland 20912

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Forest Lawn Cemetery

Date

5-12-99

20c. Location - City or Town, State

Omaha, Nebraska

21. Signature of Funeral Service Licensee

Carolea Delm

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, Maryland 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

4 years

Due to (or as a consequence of):

Arteriosclerotic Heart Disease

10 years

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George F. Sengstack, M.D.

29c. License number

D12121

29d. Date signed (Month, Day, Year)

May 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George F. Sengstack, M.D., 3929 Ferrara Drive, Wheaton, Maryland 20906-4709

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16049

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Olin Louis Stout</b>			2. Date of Death Month <b>May</b> Day <b>3</b> Year <b>1999</b>		3. Time of Death <b>2:30P.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Crescent City Center</b>			4b. City, Town, or Location of Death <b>Riverdale</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>450-07-7787</b>		8. Sex <b>XXM</b> 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1911</b>
	9. Birthplace (State or Foreign Country) <b>Paris, Texas</b>						
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Beltsville</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>11334 Melclare Drive</b>				10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Intelligence Analyst</b>		16b. Kind of Business/Industry <b>U.S. Government</b>	
17. Father's Name (First, Middle, Last) <b>B. Stout</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Della Creech</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Euphama Stout (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cemetery</b>		Date <b>5/6/1999</b>		20c. Location - City or Town, State <b>Adelphi, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIO SCLEROTIC CARDIOVASCULAR Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's Disease</b> <b>Cerebral Infarction</b>							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Paul A. DeVore</b>				29c. License number <b>D01852</b>		29d. Date signed (Month, Day, Year) <b>May 4, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul A. DeVore, M.D. 4203 Queensbury Road Hyattsville, Maryland 20781</b>							
31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>		32. Registrar's Signature <b>B. Sparks</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 29c, 5/5/99

State of Maryland / Department of Health and Mental Hygiene

Per Field Rep., Carroll County, wjl

Certificate of Death

Reg. No.

16050

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joyce Stewart				2. Date of Death Month Day Year May 3 1999				3. Time of Death 8:22am	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 090-58-0192		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) May 23 1925		9. Birthplace (State or Foreign Country) Jamaica, WI	
	Usual Residence of Decedent									
10a. State Md		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1300 Windglass Drive				10f. Zip Code 21220		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) seamstress				16b. Kind of Business/Industry fashion		
17. Father's Name (First, Middle, Last) Arthur Evans				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Badchkam						
19a. Informant's Name/Relationship (Type, Print) Maureen Hosang (daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104-50 194th St., St. Albans, NY 11412						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Mem. Park		Date 5/8/99		20c. Location - City or Town, State Coram, New York				
21. Signature of Funeral Service Licensee Brian L. Hight				22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 10 days		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency, Diabetes Mellitus, Coronary Artery Disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Deborah L. Gallo		29c. License number P12082 RD 187187		29d. Date signed (Month, Day, Year) 5/3/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Deborah Gallo 9000 Franklin Square Drive, Baltimore, MD 21237										
31. Date filed (Month, Day, Year) MAY 05 1999		32. Registrar's Signature Geneva G. Sparks								

Joyce Stewart

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16051

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWARD S. TURNER

2. Date of Death

Month Day Year  
4 28 99

3. Time of Death

0445

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

578-03-2618

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
5-21-12

9. Birthplace (State or Foreign Country)

WASH., DC

Usual Residence of Decedent

10a. State

Md.

10b. County

WORCESTER

10c. City, Town or Location

OCEAN PINES

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9 SANDY CIRCLE

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROPERTY MANAGER

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

EDWARD W. TURNER

18. Mother's Name (First, Middle, Maiden Surname)

EMILY FREEMAN

19e. Informant's Name/Relationship (Type, Print)

KATHRYN R. TURNER

SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 SANDY CIR., OCEAN PINES, MD., 21811

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GEO. WASHINGTON CEM. 5-1

Date

20c. Location - City or Town, State

ADELPHI, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD/

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

pneumonia

Due to (or as a consequence of):

b.

hip fracture

Due to (or as a consequence of):

c.

Alzheimer's dementia

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D54127

29d. Date signed (Month, Day, Year)

4/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DAVIS 3 Bishole Blvd Delmar MD 21875

31. Date filed (Month, Day, Year)

APR 29 1999

32. Registrar's Signature

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16052

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Mary Macklem Spies</b>				2. Date of Death Month <b>05</b> Day <b>04</b> Year <b>99</b>		3. Time of Death <b>6:30 p.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>Caroline Nursing Home, Inc.</b>				4b. City, Town, or Location of Death <b>Denton, MD</b>		4c. County of Death <b>Caroline</b>	
5. Social Security Number <b>714-74-4549</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>08/02/1900</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Easton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. Street and Number <b>Square Farm Chapel Road</b>				10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>1+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>William Jacob Macklem</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sara Katherine Walker</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary Ann Todd/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6224 Bethlehem Rd., Preston, MD 21655</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Spring Hill Cemetery</b>		Data <b>5/7/99</b>		20c. Location - City or Town, State <b>Easton, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Michael F. Eskow</b>				22. Name and Address of Facility <b>Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>congestive heart Failure</b> years Due to (or as a consequence of): b. <b>Coronary Artery Disease</b> years Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Hypertension</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>James Sides MD</b>				29c. License number <b>D31376</b>		29d. Date signed (Month, Day, Year) <b>5-5-99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James Sides 920 Market St Denton MD 21629</b>							
31. Date filed (Month, Day, Year) <b>MAY 06 1999</b>				32. Registrar's Signature <b>B. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020 fdl  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16053

1. Decedent's Name (First, Middle, Last) <b>Dianne M. Potter Smith</b>				2. Date of Death Month <b>May</b> Day <b>03</b> Year <b>1999</b>		3. Time of Death <b>2:40 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>1316 Nome Street</b>				4b. City, Town, or Location of Death <b>Chapel Oaks</b>		4c. County of Death <b>Prince George's</b>	
5. Social Security Number <b>579-72-9019</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 13, 1954</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD.</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>District Heights</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2118 County Road #T1</b>		10f. Zip Code <b>20747</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bus Driver</b>		16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) <b>Robert Potter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Stokes</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Sharron Smith/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2118 County Road #T1 District Heights, MD. 20747</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		20c. Location - City or Town, State <b>Beltsville, MD.</b>		20d. Date	
21. Signature of Funeral Service Licensee <i>Janice Edwards</i>		22. Name and Address of Facility <b>Hodges &amp; Edwards F.H. 3910 Silver Hill RD. Suitland, MD. 20746</b>					

To Be Completed by Funeral Director

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>COCAINE INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>  <b>Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 5-3-99</b>		28b. Time of Injury <b>UNKNOWN</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred <b>UNKNOWN</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN A HOME</b>					
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1316 NOME ST., CHAPEL OAKS, MD</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Wayne D. Melchior</i>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>May 03, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WISLEYA KOBAN UN 111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>MAY 17 1999</b>		32. Registrar's Signature <i>James H. Sparks</i>					

To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Freda Taff</b>		2. Date of Death Month Day Year <b>May 4, 1999</b>		3. Time of Death <b>11:55 AM</b>	
4a. Facility Name (If not Institution, give street and number) <b>5225 POOKS HILL ROAD</b>			4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>
5. Social Security Number <b>579-68-5641</b>		8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) <b>OCT. 15, 1914</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>	
10a. State <b>MARYLAND</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>BETHESDA</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>5225 POOKS HILL ROAD #609N</b>			10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>UNITED STATES</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>	
16b. Kind of Business/Industry <b>OWN HOME</b>		17. Father's Name (First, Middle, Last) <b>HARRY VIENER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>FANNIE MATILDA SHARP</b>	
19a. Informant's Name/Relationship (Type, Print) <b>DEBBIE STAR (DAUGHTER)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9600 HALTER COURT - POTOMAC, MARYLAND 20854</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Remove from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>JUDEAN MEMORIAL GARDEN</b>		20c. Location - City or Town, State <b>OLNEY, MARYLAND</b>	
21. Signature of Funeral Service Licenses		22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. CONJESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>b. AORTIC STENOSIS</b> Due to (or as a consequence of): <b>c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death <b>6 MONTHS</b> <b>YEARS</b> <b>YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D10242</b>		29d. Date signed (Month, Day, Year) <b>5/4/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MORTON SHAPIRO, MD - 5225 POOKS HILL ROAD #1 - BETHESDA, MARYLAND 20814</b>					
31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>		32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Taffeta

TARPLEY

AMEND#23a,27-28f G771 6-3-99 J.A.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Taffeta Louisa Tarpley

2. Date of Death

Month  
MAYDay  
4, 1999

3. Time of Death

6:35P.M.

4a. Facility Name (If not institution, give street and number)

7843 RIVERDALE ROAD

4b. City, Town, or Location of Death

NEW CARROLTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

230-76-5715

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 4, 1950 Washington, D.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland Prince George's

New Carrollton

10e. Street and Number

7843 Riverdale Road

10f. Zip Code

20784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Maryland State Gov't.

17. Father's Name (First, Middle, Last)

James Harold Tarpley

18. Mother's Name (First, Middle, Maiden Surname)

Bette Jane Morris

19a. Informant's Name/Relationship (Type, Print)

Bonnie Theresa Sabo (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2710 Sheraton Street Wheaton, Maryland 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

E. S. Seels

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

COMBINED DRUG INTOXICATION

a. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☒ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

FOUND MAY 4, 1999

28b. Time of Injury

p m

6:25

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RESIDENCE

28d. Describe how injury occurred

SUBJECT INGESTED DRUG

28f. Location (Street and Number or Rural Route Number, City or Town, State)

7843 RIVERDALE RD. APT-203 NEW CARROLTON, MD.

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore M. King

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16056

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SAMUEL R. THOMPSON

2. Date of Death

Month Day Year  
MAY 3, 1999

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

707 Dryden Street

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

213-24-3961

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 17, 1926

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 Dryden Street

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 46-4713. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Personnel Assistant

16b. Kind of Business/Industry

Food & Drug  
Administration

17. Father's Name (First, Middle, Last)

Samuel R. Thompson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Harriet Swailes

19a. Informant's Name/Relationship (Type, Print)

Alice J. Thompson (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

707 Dryden St., Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cem.

Date

5/7/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sudden

b. Diabetes Mellitus

Due to (or as a consequence of):

Years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-32332

29d. Date signed (Month, Day, Year)

April 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh K. Gupta, M.. 9801 Georgia Ave., #220, Silver Spring, MD 20902

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 06 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16057

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Allan Fitzhugh Thornton, Sr.				2. Date of Death Month Day Year May 2, 1999				3. Time of Death 9:00pm	
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center				4b. City, Town, or Location of Death Gaithersburg				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-42-4082		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 18, 1912		9. Birthplace (State or Foreign Country) Minnesota	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 415 Russell Avenue #816				10f. Zip Code 20877		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Economist				16b. Kind of Business/Industry Federal Government		
17. Father's Name (First, Middle, Last) Manly Philip Thornton				18. Mother's Name (First, Middle, Maiden Surname) Mabel Chandler						
19a. Informant's Name/Relationship (Type, Print) Idabeth Thornton (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Russell Avenue #816, Gaithersburg, MD 20877						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Date 5/3/99		20d. Location - City or Town, State Alexandria, Virginia				
21. Signature of Funeral Service Licensee <i>Robert A. DeVol</i>				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Renal failure</i> Due to (or as a consequence of): b. <i>Obstructive uropathy</i> Due to (or as a consequence of): c. <i>Carcinoma of prostate</i> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 10 Months		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Radiation fibrosis</i> <i>congestive heart failure</i> <i>summary of chronic disease</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>H. Robert Birschbach, M.D.</i>				29c. License number 04115		29d. Date signed (Month, Day, Year) May 3, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H. Robert Birschbach, M.D. 6320 Democracy Blvd., Bethesda, MD 20817										
31. Date filed (Month, Day, Year) MAY 05 1999		32. Registrar's Signature <i>B. Sparks</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

15 (10)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16058

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WOLF B. TOPCHIK			2. Date of Death Month Day Year May 2 1999		3. Time of Death 4:36 AM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital			4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 135-20-3273		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 102 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 26, 1896
	9. Birthplace (State or Foreign Country) RUSSIA						
Usual Residence of Decedent							
10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location BETHESDA		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 9910 FERNWOOD ROAD				10f. Zip Code 20817		10g. Citizen of What Country? UNITED STATES	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TAILOR		16b. Kind of Business/Industry MANUFACTURER COATS & DRESSES	
17. Father's Name (First, Middle, Last) SHMUEL HIRSH TOPCHIK				18. Mother's Name (First, Middle, Maiden Surname) CHAIYA TOPCHIK (GAZMAN)			
19a. Informant's Name/Relationship (Type, Print) SYLVIA LEVINE (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9910 FERNWOOD ROAD - BETHESDA, MARYLAND 20817			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERSIDE CEMETERY		Date 5/4/99		20c. Location - City or Town, State GARFIELD, NEW JERSEY	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. CENTRAL HYPOVENTILATION Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA, DYSPHAGIA, ACUTE CHOLECYSTITIS							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and Title of Certifier 				29c. License number D26571		29d. Date signed (Month, Day, Year) 5/2/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRVING MIZUS, MD 4930 DEL RAY AVE BETHESDA, MD 20814							
31. Date filed (Month, Day, Year) MAY 03 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16059

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard A. Townsend				2. Date of Death Month: May Day: 1 Year: 1999		3. Time of Death 1:25AM	
	4e. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 219-05-5961		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 13, 1920	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Virginia		10b. County Arlington		10c. City, Town or Location None	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 528 N. George Mason Dr.		10f. Zip Code 22203	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4or 5+): 2	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant				16b. Kind of Business/Industry US Postal Service			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Edgar Franklin Townsend				18. Mother's Name (First, Middle, Maiden Surname) Clara Conrad			
	19a. Informant's Name/Relationship (Type, Print) Shirley Townsend, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10219 Great Plains Ln., Houston, TX. 77064			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Arlington Funeral Home 3901 N. Fairfax Dr., Arl., Va.			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Cirrhosis Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 7 Days 15 years 7 Days			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Jay Weiner			
To Be Completed by Physician/Medical Examiner	29c. License number 024578				29d. Date signed (Month, Day, Year) May 1, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jay Weiner 11501 Georgia Ave Wheaton, Md				31. Date filed (Month, Day, Year) MAY 03 1999			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature B. Sparks				33. Date of Death May 1, 1999			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16060

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPHINE TUCKER

2. Date of Death

April 29, 1999

3. Time of Death

5:25 A.M.

4a. Facility Name (If not institution, give street and number)

Brooke Grove Rehab &amp; Nursing Ctr.

4b. City, Town, or Location of Death

Olney

4c. County of Death

MONTGOMERY

5. Social Security Number

075-18-3665

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Nov. 25, 1914

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

17333 Blossom View Drive

10f. Zip Code

20832

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Chamber Maid

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Moses Tucker

18. Mother's Name (First, Middle, Maiden Surname)

Ann Hill

19a. Informant's Name/Relationship (Type, Print)

Martha Strother (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17333 Blossom View Dr., Olney, MD 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cem.

Date

5/4/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 33700

29d. Date signed (Month, Day, Year)

APRIL 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ted E. Howe, M.D. 7542 Overlook Dr. Boonsboro, MD 21713

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16061

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY HELEN TRICHILO				2. Date of Death Month Day Year April 29, 1999				3. Time of Death 0430	
	4a. Facility Name (If not Institution, give street and number) 410 BALDWIN DR., APT. A3				4b. City, Town, or Location of Death WESTMINSTER				4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 209-18-5007		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 9/24/1910		9. Birthplace (State or Foreign Country) CANADA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County CARROLL		10c. City, Town or Location WESTMINSTER				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 410 BALDWIN DR., APT. A3				10f. Zip Code 21157		10g. Citizen of What Country? USA.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE				16b. Kind of Business/Industry HOME MAKER			
	17. Father's Name (First, Middle, Last) FRANK BUMBACO				18. Mother's Name (First, Middle, Maiden Surname) AGATHA OLIVIERI					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PAULINE TRICHILO -DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 BALDWIN DR., APT. A3, WESTMINSTER, MD. 21157					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LAKE VIEW MEM. PARK		Date 5/3/99		20c. Location - City or Town, State ELDERSBURG, MD.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular fibrillation Due to (or as a consequence of): b. Congestive heart failure Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D18200		29d. Date signed (Month, Day, Year) 4/30/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRACHEDU NAG ANANTA MD 700-A Poole Rd Westminister MD 21157									
	31. Date filed (Month, Day, Year) MAY 03 1999				32. Registrar's Signature 					



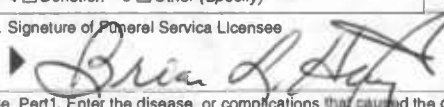
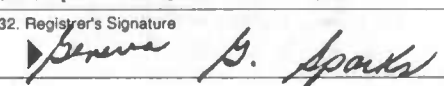
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16062

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JACK TYLER THOMAS</b>		2. Date of Death Month: <b>MAY</b> Day: <b>02</b> Year: <b>1999</b>		3. Time of Death <b>3:00 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>227-36-6397</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) <b>Aug 14 1929</b>		9. Birthplace (State or Foreign Country) <b>Va.</b>		
Usual Residence of Decedent					
10a. State <b>Md</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1 Pebble Drive</b>		10f. Zip Code <b>21225</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1952-1954</b>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12</b> College (1-4 or 5+):	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>diesel mechanic</b>		16b. Kind of Business/Industry <b>automotive</b>			
17. Father's Name (First, Middle, Last) <b>Kirby S. Thomas</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Belle Stinson</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Yvonne Marie Thomas (spouse)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Pebble Drive, Baltimore, Md 21225</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crownsville Veterans Cem</b>		20c. Location - City or Town, State <b>5-6-99 Crownsville, Md</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, Md 21784</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) e. <b>ACUTE CEREBRAL INFARCTION</b> 7 days					
Due to (or as a consequence of): b. <b>HYPERTENSION</b> 5-10 yrs.					
Due to (or as a consequence of): c. <b>CORONARY ARTERY DISEASE</b> 5-10 yrs.					
Due to (or as a consequence of): d. <b>STENOSIS LEFT INTERNAL CAROTID ARTERY</b> 2 YEARS					
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBRA ANEURYSM 1997</b> <b>COLON RESECTION 1950</b> <b>RIGHT HIP FRACTURE PINNING</b>					
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D28988</b>		29d. Date signed (Month, Day, Year) <b>MAY 2, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Lino R. Arquillano MD, 3601 S. HANOVER ST. BALT. MD 21225</b>					
31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2001. 2nd April

1998. 1st April

1997. 1st April

1996. 1st April

1995. 1st April

1994. 1st April

1993. 1st April

1992. 1st April

1991. 1st April

1990. 1st April

1989. 1st April

1988. 1st April

1987. 1st April

1986. 1st April

1985. 1st April

1984. 1st April

1983. 1st April

1982. 1st April

1981. 1st April

1980. 1st April

1979. 1st April

1978. 1st April

1977. 1st April

1976. 1st April

1975. 1st April



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16063

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Udris

2. Date of Death

May 3, 1999

3. Time of Death

6:30PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9714 Hedin Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

155-24-7307

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 25, 1909

9. Birthplace (State or Foreign Country)

Latvia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9714 Hedin Drive

10f. Zip Code

20903

10g. Citizen of What Country?

United States &amp; Latvia

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Grocery Chain

17. Father's Name (First, Middle, Last)

Gustavs Zemgals

18. Mother's Name (First, Middle, Maiden Surname)

Emilija Tidens

19a. Informant's Name/Relationship (Type, Print)

Ilze U. Black/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1416 Laburnum Street, McLean, Virginia 22101

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

May 9, 1999

Montgomery Crematorium, Inc.

Date

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00198

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc.

7557 Wisconsin Avenue

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24886

29d. Date signed (Month, Day, Year)

May 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark H. Eig, M.D. 10801 Lockwood Drive, #280, Silver Spring, Maryland 20901

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16064

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMETERIO VALLEJOS				2. Date of Death Month Day Year MAY 2, 1999		3. Time of Death 8:30 P.M.	
	4a. Facility Name (If not institution, give street and number) MEDIPLEX OF MONTGOMERY VILLAGE				4b. City, Town, or Location of Death MONTGOMERY VILLAGE MONTGOMERY		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 228-78-3619		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 2, 1916	
	9. Birthplace (State or Foreign Country) ARGENTINA		10a. State VIRGINIA		10b. County FAIRFAX		10c. City, Town or Location BURKE	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 10003 BEACON POND LANE		10f. Zip Code 22015		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHEF		16b. Kind of Business/Industry RESTAURANT INDUSTRY				
17. Father's Name (First, Middle, Last) RAMON VALLEJOS				18. Mother's Name (First, Middle, Maiden Surname) SOPHIA SOLIS				
19a. Informant's Name/Relationship (Type, Print) EDWARD VALLEJOS - SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10003 BEACON POND LANE, BURKE, VIRGINIA 22015				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NATIONAL MEMORIAL PARK		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA		20d. Date 5-6-99		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 20904 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MD				
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. PNEUMONIA Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Approximate Interval Between Onset and Death 5 YEARS 11/2 MONTHS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION GASTROINTESTINAL TUBE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D18726		29d. Date signed (Month, Day, Year) MAY 3, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SCHOENGOLD, 18111 PRINCE PHILIP DRIVE, SUITE T-10, OLNEY, MARYLAND 20832								
31. Date filed (Month, Day, Year) MAY 06 1999		32. Registrar's Signature 						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16065

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Kopel Mendeleovich Volchok</b>						2. Date of Death Month Day Year <b>May 3 1999</b>			3. Time of Death <b>6:00 PM</b>	
4a. Facility Name (If not Institution, give street and number) <b>17120 Queen Victoria Court</b>						4b. City, Town, or Location of Death <b>Gaithersburg</b>			4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>216-53-3771</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 2, 1911</b>		9. Birthplace (State or Foreign Country) <b>Russia</b>		
Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>17120 Queen Victoria Court</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>Russia</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Technical Editor</b>			16b. Kind of Business/Industry <b>Publishing House</b>			
17. Father's Name (First, Middle, Last) <b>Mendel Volchok</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Haya-Shayevna (Unknown)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Viktor E. Segal/Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>261 Congressional Lane Apt. 609 Rockville, MD 20852</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Lebanon Cemetery</b>		Date <b>5/7/99</b>		20c. Location - City or Town, State <b>Adelphi, MD</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stein Hebrew Memorial Funeral Home 232 Carroll St. NW Washington, DC 20012</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Coronary Artery Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and Title of certifier  M.D.				29c. License number <b>D46364</b>			29d. Date signed (Month, Day, Year) <b>May 6, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sokolsky Felix, MD 11125 Rockville Pike #203 Rockville, MD 20852</b>										
31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16066

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SARAH ESTERLEEN VINCENT</b>						2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>1719</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>249-26-0103</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth Month <b>10</b> Day <b>19</b> Year <b>1921</b>		9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>POCOMOKE CITY</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2123 Bypass Road</b>				10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>DOMESTIC</b>			
17. Father's Name (First, Middle, Last) <b>ROBERT LEE RICHARDSON</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>RETHA LOVELL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>WALLACE CLAYTON VINCENT (Spouse)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2123 Bypass Rd, Pocomoke City, MD 21851</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETHANY U.M. CEM.</b>			20c. Date <b>5/5/99</b>		20d. Location - City or Town, State <b>POCOMOKE CITY, MD</b>		
21. Signature of Funeral Service Licensee <b>Michael A Dean 101129</b>						22. Name and Address of Facility <b>HOLLOWAY MELSON F.H., P.A. 103 LINDEN AVE POCOMOKE CITY, MD</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial infarction</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>1225-674</b>		29d. Date signed (Month, Day, Year) <b>5/1/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5 J A Cockey, MD 100 Power St, Salisbury and 21854</b>										
31. Date filed (Month, Day, Year) <b>MAY 04 1999</b>			32. Registrar's Signature <b>[Signature]</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Vincent, Sarah R. 249-26-0103

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10

1947 10 10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16067

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vincent Joseph Vigneri

2. Date of Death

Month Day Year  
May 2, 1999

3. Time of Death

11:10 am

4a. Facility Name (If not institution, give street and number)

Mallard Bay Care Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

212-09-1596

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 2, 1915

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Sandy Acres Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Peter Vigneri

18. Mother's Name (First, Middle, Maiden Surname)

Marion Pondolofini

19a. Informant's Name/Relationship (Type, Print)

Peter V. Vigneri/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Talbot Ave., Cambridge, MD 21613

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cambridge Crematory 5-3-99

Date

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

*James Curran-Bromwell*

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.  
308 High St., Cambridge, MD 2161323a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)*Cardiac Arrhythmia*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death*4 min*Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last*COPD*

Due to (or as a consequence of):

*10/11/95**COP Pulmonary*

Due to (or as a consequence of):

*5 years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*My Affirmation*

29c. License number

D26385

29d. Date signed (Month, Day, Year)

5-3-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Michael F. Hollenbeck 302 Collins Huntlock MD 21643*

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

*Denise B. Sparks*State  
RegistrarBaltimore, Maryland 21215-0020  
permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 16068

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRVING L. WELCH</b>				2. Date of Death Month <b>APRIL</b> Day <b>29</b> Year <b>1999</b>		3. Time of Death <b>5:00AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Holy Cross Rehabilitation &amp; Nursing Center</b>				4b. City, Town, or Location of Death <b>Burtonsville</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>578-01-1826</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 15, 1907</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Burtonsville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3415 Greencastle Road</b>				10f. Zip Code <b>20866</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>University</b>	
17. Father's Name (First, Middle, Last) <b>George Franklin Welch</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Miles</b>			
19a. Informant's Name/Relationship (Type, Print) <b>William Welch, Sr., Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14801 Windmill Terrace, Silver Spring, Md. 20905</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>5/3/99</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b>								<b>2 weeks</b>
Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Congestive Heart Failure</b>								<b>5 years</b>
Due to (or as a consequence of):								
Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D0052457</b>		29d. Date signed (Month, Day, Year) <b>APRIL 29, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHOW, MO-PING MD 9001 SHADY GROVE COURT GAITHERSBURG MD 20877</b>								
31. Date filed (Month, Day, Year) <b>MAY 03 1999</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-16069

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary B. Weller

2. Date of Death

May 2, 1999

3. Time of Death

7:50AM

4a. Facility Name (If not institution, give street and number)

7904 Cindy Lane

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

169-16-3184

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 7, 1921

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7904 Cindy Lane

10f. Zip Code

20817-6911

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John J. Baker

18. Mother's Name (First, Middle, Maiden Surname)

Mary Nolan

19a. Informant's Name/Relationship (Type, Print)

John P. Weller / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7904 Cindy Lane, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Peter &amp; Paul Cemetery

Date

May 6, 1999

20c. Location - City or Town, State

Springfield, Pennsylvania

21. Signature of Funeral Service Licensee

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

months

b. Cardiomyopathy, dilated

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular Disease

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Lewis Cahill, M.D.

29c. License number

D05256

29d. Date signed (Month, Day, Year)

May 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lewis Cahill, M.D. 6000 Executive Blvd., #300, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16070

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVELYN A. WILLIAMS</b>				2. Date of Death Month Day Year <b>MAY 4, 1999</b>		3. Time of Death <b>12:41 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>090-66-4837</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 2, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>JAMAICA</b>		10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>GAITHERSBURG</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>8131 CHELABERRY CT.</b>		10f. Zip Code <b>20879</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSING ASST.</b>		16b. Kind of Business/Industry <b>HEALTH CARE</b>			
	17. Father's Name (First, Middle, Last) <b>THOMAS McINTOSH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN WILLIAMS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>GLORIA WILLIAMS/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WILLIAMS FAMILY CEMETERY</b>		Date <b>5/15/99</b>		20c. Location - City or Town, State <b>DARLSTON CALEDONIA WEST MORELAND, JAMAICA</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c. METASTATIC OVARIA CANCER</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL FAILURE</b> <b>HEPATIC INSUFFICIENCY</b> <b>ENTERO COLITIS, UPPER GI BLEED</b>							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier  <b>YISA O. YUSSUF, M.D.</b>				29c. License number <b>D51083</b>		29d. Date signed (Month, Day, Year) <b>05-05-99</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>YISA O. YUSSUF, M.D. 6712 VILLAGE PARK DR., GREENBELT, MD. 20770</b>							
31. Date filed (Month, Day, Year) <b>MAY 06 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16071

AMEND #5 PER F.H. G772 6-3-99 J.A.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carl H. Winkler

2. Date of Death

Month Day Year  
April 29, 1999

3. Time of Death

12:55 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

578  
572-01-4494

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 2, 1914

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9922 Old Spring Road

10f. Zip Code

20895

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

President

16b. Kind of Business/Industry

Travel Agency

17. Father's Name (First, Middle, Last)

Herman Winkler

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude

(Not Available)

19a. Informant's Name/Relationship (Type, Print)

Frieda H. Winkler/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9922 Old Spring Road, Kensington, MD 20895

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc. April 30, 1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral thrombosis

2 days

Due to (or as a consequence of):

Arteriosclerotic Cerebral Vascular Disease

5 years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Adenocarcinoma of Prostate

Ischemic Cardiomyopathy; Chronic Atrial Fibrillation

Bilateral Frontal lobe infections

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-01948

29d. Date signed (Month, Day, Year)

April 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Blaine Fitzgerald, M.D. 8218 Wisconsin Avenue, Bethesda, MD 20814

31. Date died (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

48  
32

Winkler, Carl H. Expiration date April 29, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16072

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dolores Agnes Walsh

2. Date of Death

Month

Day

Year

May

2nd

1999

3. Time of Death

2:05pm

4a. Facility Name (If not institution, give street and number)

Carroll County General Hosp

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-03-3891

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 19, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2713 Mystic Woods Court

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Joseph T. McNaney

18. Mother's Name (First, Middle, Maiden Surname)

Marie Walsh

19a. Informant's Name/Relationship (Type, Print)

Francis X. Walsh, Jr. - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

806 Cindy Lane, Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peter's Cemetery

Date

5/6/99

20c. Location - City or Town, State

Libertytown, MD

21. Signature of Funeral Service Licensee

Catherine O. Hartzler

22. Name and Address of Facility

Hartzler Funeral Home  
11802 Liberty Rd., Libertytown, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

One week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stroke,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Sparks, MD

29c. License number

D48006

29d. Date signed (Month, Day, Year)

May 2nd, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOFI BORTLEY, 200 Memorial Ave, Westminster, MD 21157

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

D. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16073

ITEM: #5 PER MEO G772 6-9-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BLODWYN ROBERTS WHITE</b>				2. Date of Death Month <b>MAY</b> Day <b>03</b> Year <b>99</b>		3. Time of Death <b>11:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BERLIN NURSING &amp; REHAB CENTER</b>				4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>	
Funeral Director	5. Social Security Number <b>187-03-1828</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6-6-13</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		10a. State <b>MD.</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>OCEAN CITY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1504 SHAD ROW</b>		10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MANAGER</b>		16b. Kind of Business/Industry <b>RETAIL</b>				
17. Father's Name (First, Middle, Last) <b>JOHN ROBERTS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>KATHERINE DOYLE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>NANCY W. BARRETT</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 BUCKINGHAM RD. BERLIN, MD. 21811</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MAKEMIE PRESBY. CEM.</b>		20c. Location - City or Town, State <b>5-6 SNOW HILL, MD.</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD. 21811</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, attack, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Essential Hypertension</i> <i>Parkinson's Disease</i>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D29505</b>		29d. Date signed (Month, Day, Year) <b>5-4-99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GREGORIO BELLOSO, MD 5302 CHINABERRY DR. SALISBURY MD 21801 410-341-6321</b>								
31. Date filed (Month, Day, Year) <b>MAY 04 1999</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

WHITE, BLODWYN  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





WRC  
99-2438-033  
MICHAEL DAVID  
WALTER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item 27 per ME, G771-5/18/99/dhb

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael David Walter

2. Date of Death

Month Day Year  
APRIL 28, 1999

3. Time of Death

2:11 PM.

4a. Facility Name (If not institution, give street and number)

COLONIAL FARM PARK

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

214 66 0052

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 9, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

9721 Indian Princess Drive

10f. Zip Code

20744

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accountant Agriculture

16b. Kind of Business/Industry

Dept of Agriculture

17. Father's Name (First, Middle, Last)

Robert G. Walter

18. Mother's Name (First, Middle, Maiden Surname)

Marie Laffler

19a. Informant's Name/Relationship (Type, Print)

Nancy Walter (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9721 Indian Princess Drive, Fort Washington, MD 20744

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory April 29, 1999

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONTACT GUNSHOT WOUND OF HEAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

4-28-99

28b. Time of Injury

1:30 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

gunshot wound of head

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

PARK park

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Piscataway Park - Colonial Farms

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

APRIL 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

April 22 1900

1900

1900

1900

1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16075

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eleanor E. Wilson</b>				2. Date of Death Month <b>May</b> Day <b>4</b> Year <b>1999</b>		3. Time of Death <b>1:30 PM</b>											
	4a. Facility Name (If not institution, give street and number) <b>23524 Rolling Fork Way</b>				4b. City, Town, or Location of Death <b>Gaithersburg</b>		4c. County of Death <b>Maryland</b>											
Funeral Director	5. Social Security Number <b>173-24-8427</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>December 17, 1927</b>											
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>																	
Usual Residence of Decedent																		
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>23524 Rolling Fork Way</b>				10f. Zip Code <b>20882</b>		10g. Citizen of What Country? <b>U.S.A.</b>												
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Aide</b>		16b. Kind of Business/Industry <b>Montgomery County Government</b>												
17. Father's Name (First, Middle, Last) <b>Sol Davis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Stanton</b>														
19a. Informant's Name/Relationship (Type, Print) <b>Mary Ellen Cotton - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23524 Rolling Fork Way, Gaithersburg, Maryland 20882</b>														
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>5/8/99</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>											
21. Signature of Funeral Service Licensee <b>Robert L. Williams</b>				22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             {            Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>ACUTE MYOCARDIAL INFARCTION</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>MINUTES</b>   <b>years</b>   <b>years</b> </td> </tr> <tr> <td>b.</td> <td><b>HYPERTENSION</b></td> </tr> <tr> <td>c.</td> <td><b>DIABETES MELLITUS</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)  { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>ACUTE MYOCARDIAL INFARCTION</b>	Approximate Interval Between Onset and Death  <b>MINUTES</b>  <b>years</b>  <b>years</b>	b.	<b>HYPERTENSION</b>	c.	<b>DIABETES MELLITUS</b>	d.	
Immediate Cause (Final disease or condition resulting in death)  { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>ACUTE MYOCARDIAL INFARCTION</b>	Approximate Interval Between Onset and Death  <b>MINUTES</b>  <b>years</b>  <b>years</b>															
	b.	<b>HYPERTENSION</b>																
	c.	<b>DIABETES MELLITUS</b>																
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERLIPIDEMIA</b>																		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
			28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier <b>Alan Diamond MD</b>				29c. License number <b>D24245</b>		29d. Date signed (Month, Day, Year) <b>5/5/99</b>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALAN DIAMOND, 10801 LOCKWOOD DR, SILVER SPRING, MD 20901</b>																		
31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>			32. Registrar's Signature <b>B. Sparks</b>															

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16076

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth S. Zoller				2. Date of Death Month Day Year May 4, 1999		3. Time of Death 12:55 PM	
	4a. Facility Name (If not institution, give street and number) Manor Care - Largo				4b. City, Town, or Location of Death Largo		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 415-44-4207	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 3, 1901		9. Birthplace (State or Foreign Country) Tennessee
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Edgewater			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 352 Arbutus Drive			10f. Zip Code 21037		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) John Alfred Seton				18. Mother's Name (First, Middle, Maiden Surname) Nettie Mae Butler			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sally B. Zoller (daughter-in-law)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 352 Arbutus Drive Edgewater, Maryland 21037			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Shilo Cemetery		Date 5/8/99		20c. Location - City or Town, State Sevierville, Tennessee	
	21. Signature of Funeral Service Licensee Eric S. Seals				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Heart Disease</u> years Due to (or as a consequence of): b. <u>Hypertension</u> years Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia.</u>							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Rakesh Arora				29c. License number D 20108		29d. Date signed (Month, Day, Year) 5/5/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane #222 Bowie, Maryland 20715								
31. Date filed (Month, Day, Year) MAY 06 1999				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16077

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) Mary Marie Alvater				2. Date of Death Month Day Year MAY 7, 1999				3. Time of Death 11:15 AM					
4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore					
5. Social Security Number 218-22-8612		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) June 13, 1915		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Rosedale						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1228 Spring Avenue				10f. Zip Code 21237				10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Adolph Urban						18. Mother's Name (First, Middle, Maiden Surname) Johanna Kouthut							
19a. Informant's Name/Relationship (Type, Print) Mr. Leo J. Bowers/ Nephew						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11836 Mays Chapel Road Timonium, Maryland 21093							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery				Data 5/10/1999		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. Cerebrovascular Accident Dysarthria Due to (or as a consequence of): c. Mesothelioma Due to (or as a consequence of): d. Pseudobulbar Palsy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death HOURS DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE OSTEOPOROSIS										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier 				29c. License number D 25886				29d. Date signed (Month, Day, Year) May 7, 99					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204													
31. Date filed (Month, Day, Year) MAY 19 1999				32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16078

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FLORABELLE

ACREE

2. Date of Death

Month  
MAY

Day  
17<sup>th</sup>

Year  
1999

3. Time of Death

6:10am

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

212-20-2999

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year  
May 13, 1927

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2015 Jubilee Ct.

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12<sup>th</sup>

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Jerome Smith

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Knox

19a. Informant's Name/Relationship (Type, Print)

Thomas Acree

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

215 Dallas Ct Balto. MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cem. May 21/99, Owens Mills, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Patricia Betts

22. Name and Address of Facility

1129 N. Caroline St. Balto. MD. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIAC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD RESIDENT

29c. License number

P-12560

29d. Date signed (Month, Day, Year)

MAY 17<sup>th</sup> 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANU GABA MD, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

Linna B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 303.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

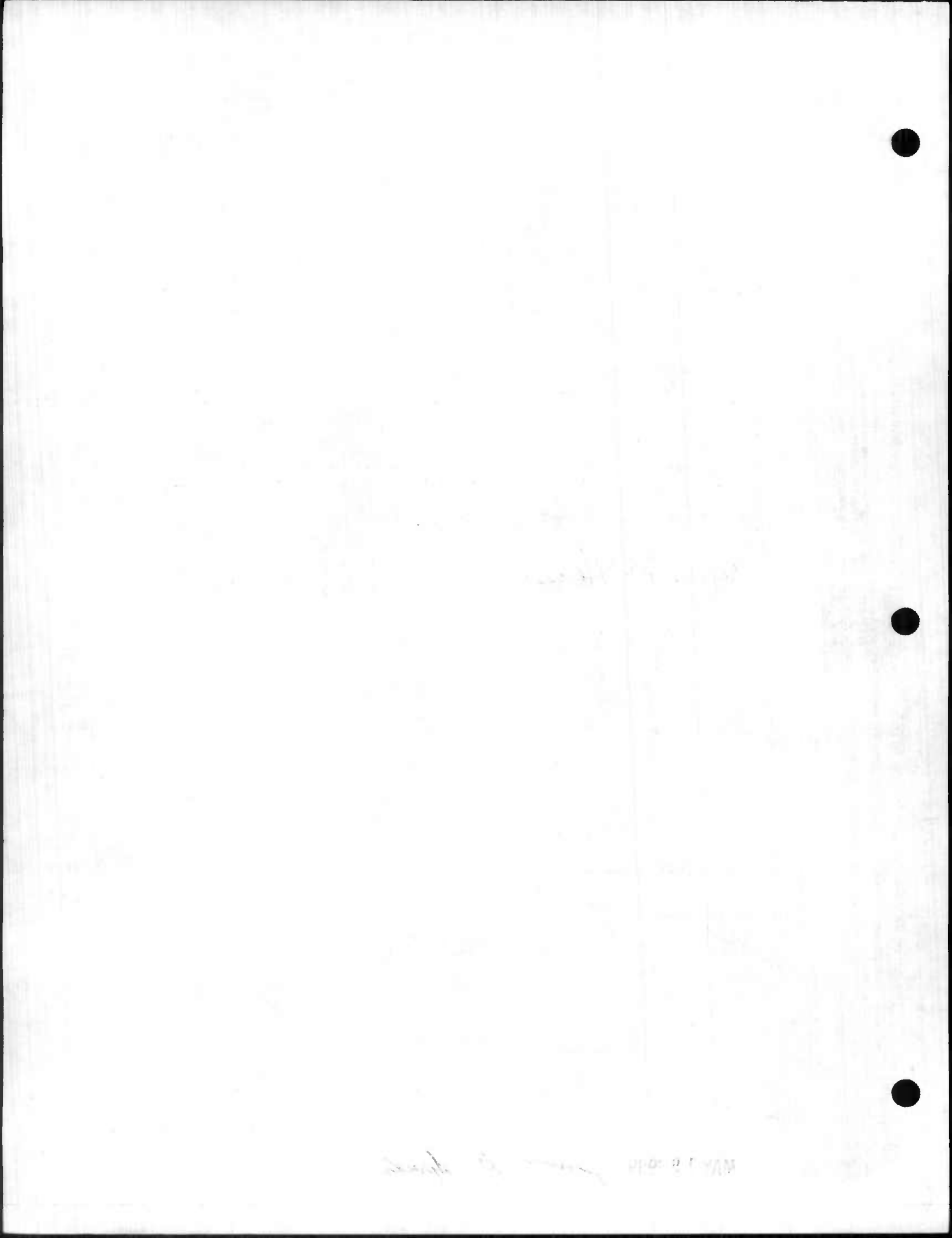
## Certificate of Death

Reg. No.

99 16079

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Philip Dirlan Bonnet</b>				2. Date of Death Month Day Year <b>May 12, 1999</b>				3. Time of Death <b>12:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3938 Beech Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>025-26-8898</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>May 28, 1911</b>		9. Birthplace (State or Foreign Country) <b>Massachusetts</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3938 Beech Avenue</b>		10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Physician</b>	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry <b>School of Public Health</b>		17. Father's Name (First, Middle, Last) <b>Frederic Bonnet</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Binns</b>		19a. Informant's Name/Relationship (Type, Print) <b>Esther Bonnet (Wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3938 Beech Avenue, Baltimore, Maryland 21211</b>	
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Washington Crematory</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>		21. Signature of Funeral Service Licensee <b>Lynn B. Henss</b>		22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland</b>	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Ventricular tachycardia - arrhythmia</b> Due to (or as a consequence of):		b. <b>Coronary atherosclerosis</b> Due to (or as a consequence of):		c. <b>Valvular heart disease</b> Due to (or as a consequence of):		d. <b>Chronic obstructive pulmonary disease</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial fibrillation</b> <b>Congestive heart failure</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Approximate Interval Between Onset and Death <b>?</b> <b>years</b> <b>years</b> <b>years</b>	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
State Registrar	29b. Signature and title of certifier <b>George D. Bittar</b>		29c. License number <b>D324343</b>		29d. Date signed (Month, Day, Year) <b>5/17/99</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE D. BITTAR</b>		31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>	
	32. Registrar's Signature <b>B. Sparks</b>		33. Date of Death (Month, Day, Year) <b>MAY 12 1999</b>		34. Date of Death (Month, Day, Year) <b>MAY 12 1999</b>		35. Date of Death (Month, Day, Year) <b>MAY 12 1999</b>		36. Date of Death (Month, Day, Year) <b>MAY 12 1999</b>	

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16080

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George L. Bailey, Sr.

2. Date of Death

Month

Day

Year

MAY

15

1999

3. Time of Death

1220am

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-05-1373

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 14, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore, Maryland

10d. Inside City Limits

XX Yes 20 No

10e. Street and Number

1235 Union Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
10 Yes 20 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
10 Yes XX No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

11

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Fire Fighter

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Ernest Paul Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Mary Catherine Otten

19a. Informant's Name/Relationship (Type, Print)

Eva Bailey Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1235 Union Avenue, Baltimore, Maryland 21211

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

Date

5/19/1999 Woodlawn, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Burgee-Henss-Seitz Funeral Home, Inc. 21211

22. Name and Address of Facility

3631 Falls Road, Baltimore, Maryland

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Tachyarrhythmia, uncompensated

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. perioperative myocardial infarction

Due to (or as a consequence of):

2 days

c. Chronic renal failure

Due to (or as a consequence of):

1 year

d. Rectal Carcinoma

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

recurrent CVA's

atherosclerotic disease peripheral vascular disease

hypothyroidism

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural

50 Pending investigation

20 Accident

60 Could not be determined

30 Suicide

40 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph A. Besso Jr. MD Surgeon

29c. License number

AT2438946.N33

29d. Date signed (Month, Day, Year)

MAY 15 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH A Besso Jr. Union Memorial Hospital

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16081

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOLORES BULL</b>				2. Date of Death Month <b>MAY</b> Day <b>18</b> Year <b>1999</b>		3. Time of Death <b>3:35PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>218-22-3535</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 10, 1927</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Upperco</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>15681 Dover Rd.</b>				10f. Zip Code <b>21155</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Black &amp; Decker</b>			
17. Father's Name (First, Middle, Last) <b>G. Raymond Jackson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Addie M. Bayne</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Sharon Osborn</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15206 Old Hanover Rd., Upperco, Md. 21155</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens May 21, 1999</b>		Date <b>May 21, 1999</b>		20c. Location - City or Town, State <b>Finksburg, Md.</b>			
21. Signature of Funeral Service Licensee <b>J. S. S. S.</b>				22. Name and Address of Facility <b>Eckhardt Funeral Chapel 3296 Charmil Dr. Manchester, Md. 21102</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>pneumonia</b> Due to (or as a consequence of): b. <b>metastatic breast cancer</b> Due to (or as a consequence of): c. <b>breast cancer</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>3 Days</b> <b>3 months</b> <b>3 years</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>M. Kaminski, MD</b>				29c. License number <b>D31339</b>		29d. Date signed (Month, Day, Year) <b>5/19/1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. Kaminski, MD - 6701 N. Charles Suite 504 Balt MD 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <b>B. Sparks</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar

NAME: BULL, Dolores L.

12 AM

100-10117-100

100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

100-10117-100

99-2775-510

UNK 99-102

asp

Michael Brooks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16082

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michael Pentis Brooks</b>				2. Date of Death Month Day Year <b>MAY 14 1999</b>				3. Time of Death <b>3:25 A</b>		
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>218-60-7760</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-10-54</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>517 N. Rose Street</b>				10f. Zip Code <b>21205</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unemployed</b>				16b. Kind of Business/Industry <b>NA</b>			
17. Father's Name (First, Middle, Last) <b>James N. Brooks</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian S. Moore</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Sean Brooks, Sr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21218</b> <b>209 East 23rd. Street Baltimore, Maryland</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		Date <b>05-20-99</b>		20c. Location - City or Town, State <b>Dundalk, MD</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Gunshot wound of Abdomen</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>5/14/99</b>		28b. Time of Injury <b>0230 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>MAY 14, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JERON LOCKE, MD</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>MAY 18 1999</b>		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-1234.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16083

ITEMS: #23 PART I, 27 PER MEO G771 5-24-99 WR.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Paul J. Bartko

2. Date of Death

May 14, 1999

3. Time of Death

5:20 P.M.

4a. Facility Name (If not institution, give street and number)

2107 Birch Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

218-60-5826

6. Sex

M 2 F

7. Age (In yrs. last birthday)

45

8. Date of Birth

Sept. 8, 1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

2107 Birch Road

10f. Zip Code

21221

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 Years

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hydraulic Repairman

16b. Kind of Business/Industry

Hydraulics

17. Father's Name (First, Middle, Last)

Michael F. Bartko, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lakatos

19a. Informant's Name/Relationship (Type, Print)

Mrs. Rose A. Bartko/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

805 North Marlyn Ave. Essex, Maryland 21221

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Ht. of Jesus Cem.

Date

5/18/99

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home

5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

Benjamin J. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature and date: 10/10/10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16084

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emerson A. Branch</b>		2. Date of Death Month Day Year <b>May 17 1999</b>		3. Time of Death <b>3:10 Am</b>									
	4a. Facility Name (If not institution, give street and number) <b>CATON MANOR GENESIS ELDER CARE</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>—</b>									
Funeral Director	5. Social Security Number <b>212-09-6458</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.									
	8. Date of Birth (Month, Day, Year) <b>Dec. 14, 1905</b>		9. Birthplace (State or Foreign Country) <b>Va.</b>											
Usual Residence of Decedent														
10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>										
10d. Inside City Limits <b>1 X 2 No</b>														
10e. Street and Number <b>4001 Dorchester Road</b>			10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>USA</b>									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b> Specify:										
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>		16b. Kind of Business/Industry <b>Domino Sugar Company</b>										
17. Father's Name (First, Middle, Last) <b>Edward Branch</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Essie unknown</b>											
19a. Informant's Name/Relationship (Type, Print) <b>friend</b> <b>Marlene Peters</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5230 Farm Pond Lane Columbia, Md. 21045</b>											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forrest Veterans</b>		20c. Location - City or Town, State <b>May 24 Owings Mills, Md.</b>										
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             {            Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last         </td> <td>a. <b>Pneumonia</b></td> <td>Approximate Interval Between Onset and Death <b>1 week</b></td> </tr> <tr> <td>b. <b>Large Subdural Hematoma</b></td> <td><b>4 weeks</b></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	a. <b>Pneumonia</b>	Approximate Interval Between Onset and Death <b>1 week</b>	b. <b>Large Subdural Hematoma</b>	<b>4 weeks</b>	c. _____		d. _____	
Immediate Cause (Final disease or condition resulting in death)  { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	a. <b>Pneumonia</b>	Approximate Interval Between Onset and Death <b>1 week</b>												
	b. <b>Large Subdural Hematoma</b>	<b>4 weeks</b>												
	c. _____													
	d. _____													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dysphagia</b> <b>Atrial Fibrillation</b>														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred												
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <b>W. Lynne M.D. Attending Doctor</b>		29c. License number <b>D 21684</b>		29d. Date signed (Month, Day, Year) <b>5-18-1999</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C.V. CYRIAC. M.D. 8109 RITCHIE HWY, PASADENA, MD 21122</b>														
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>												

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16085

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARIE F. BOSSE</b>				2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1999</b>				3. Time of Death <b>6:10PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>CHURCH HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>216-12-3261</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JAN. 4, 1908</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>				
	Usual Residence of Decedent										
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>914 S. HIGHLAND AVE.</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN TO ME</b>				
17. Father's Name (First, Middle, Last) <b>HENRY McNEW</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET FAAS</b>							
19a. Informant's Name/Relationship (Type, Print) <b>GEORGE D. BOSSE SR.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>918 S. HIGHLAND AVE. BALTO. MD. 21224</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SAC. HEART OF JESUS</b>		Date <b>MAY 20 1999</b>		20c. Location - City or Town, State <b>BALTO. CO. MD.</b>					
21. Signature of Funeral Service Licensee <i>Thomas J. ...</i>				22. Name and Address of Facility <b>HOFFMANN-SKADAFH 3218 HUDSON ST BALTIMORE, MD. 21224</b>							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of): b. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): c. <b>AORTIC STENOSIS</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>DAYS</b> <b>YEARS</b> <b>YEARS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and Title of certifier <i>Paul Gormley MD</i>				29c. License number <b>D18587</b>		29d. Date signed (Month, Day, Year) <b>MAY 16 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL GORMLEY 100 N. BROADWAY BALTIMORE MD 21231</b>											
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <i>Henry S. Sparks</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16086

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STEPHANIE T. BACKERT</b>						2. Date of Death Month <b>5</b> Day <b>17</b> Year <b>99</b>		3. Time of Death <b>1845</b>	
	4e. Facility Name (If not Institution, give street and number) <b>SHOCK TRAUMA CENTER</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>	
Funeral Director	5. Social Security Number <b>219-01-9702</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-20-1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8821 Green Needle Drive</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>			16b. Kind of Business/Industry <b>Food Store</b>			
17. Father's Name (First, Middle, Last) <b>Joseph Bena</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Theresa Stack</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barry Bena -Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>105 N.W. 64th Court, Miami, Florida, 33126</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore National Cemt.</b>			Date <b>5-21-99</b>		20c. Location - City or Town, State <b>Catonsville, Md.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Leonard J. Ruck Funeral Home Inc. 5305 Harford Rd. Baltimore, Md. 21214</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>a. <b>Multiple organ failure</b> Due to (or as a consequence of): <b>7 days</b></p> <p>b. <b>Subdural hematoma</b> Due to (or as a consequence of): <b>24 days</b></p> <p>c. <b>Fall</b> Due to (or as a consequence of): <b>24 days</b></p> <p>d. _____</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Mitral valve replacement, Congestive heart failure, Anticoagulation meds, Hypertension, TB of lung</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>4/24/99</b>		28b. Time of Injury <b>1400 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Fall from bed.</b>	
28e. Place of Injury - (At home, farm, street, factory, office building, etc. (Specify)) <b>HOME</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8821 GREEN NEEDLE DRIVE, BALTIMORE, MD 21236</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>BM00007</b>		29d. Date signed (Month, Day, Year) <b>5/17/99</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>THOMAS J. FERRER 22 SOUTH GREENE ST. BALTIMORE MD 21201</b>										
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16087

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louis J. Corvi</b>				2. Date of Death Month Day Year <b>MAY 18, 1999</b>		3. Time of Death <b>12:05 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>187-16-2576</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 6, 1921</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>106 Kingston Road</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>			16b. Kind of Business/Industry <b>Fabricator</b>		
17. Father's Name (First, Middle, Last) <b>Domonic Corvi</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ida DiBlaso</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ronald Griffith (son-in-law)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2010 Birch Road, Baltimore, Maryland 21221</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens</b>		Date <b>5/21/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of): <b>b. PNEUMONIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>urinary tract infection</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D37254</b>		29d. Date signed (Month, Day, Year) <b>5-18-99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BOON P. LIM M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>									
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16088

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Fred S. Cunningham, Jr						2. Date of Death Month Day Year MAY 15 1999		3. Time of Death 0826																	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital						4b. City, Town, or Location of Death Baltimore,		4c. County of Death N/A																	
Funeral Director	5. Social Security Number 212-34-6161		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 8, 1936		9. Birthplace (State or Foreign Country) Maryland																	
	Usual Residence of Decedent																									
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																		
10e. Street and Number 3621 Roland Avenue						10f. Zip Code 21211		10g. Citizen of What Country? USA																		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seaman				16b. Kind of Business/Industry Private Merchant Ship																		
17. Father's Name (First, Middle, Last) Fred S. Cunningham, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Ida May Fisher																				
19a. Informant's Name/Relationship (Type, Print) Betty Mort Sister						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3712 Falls Road, Baltimore, Maryland 21211																				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 5/18/99		20c. Location - City or Town, State Glen Burnie, Maryland																		
21. Signature of Funeral Service Licensee Brynn B. Henss						22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland																				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>Sepsis</td> <td>Due to (or as a consequence of):</td> <td>1 day</td> </tr> <tr> <td>b.</td> <td>Ischemic Bowel</td> <td>Due to (or as a consequence of):</td> <td>2 weeks</td> </tr> <tr> <td>c.</td> <td>Coronary Artery Disease</td> <td>Due to (or as a consequence of):</td> <td>10 years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Sepsis	Due to (or as a consequence of):	1 day	b.	Ischemic Bowel	Due to (or as a consequence of):	2 weeks	c.	Coronary Artery Disease	Due to (or as a consequence of):	10 years	d.			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Sepsis	Due to (or as a consequence of):	1 day																						
	b.	Ischemic Bowel	Due to (or as a consequence of):	2 weeks																						
	c.	Coronary Artery Disease	Due to (or as a consequence of):	10 years																						
	d.																									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																										
29b. Signature and title of certifier Eric C. Marshall MD						29c. License number AT2438946		29d. Date signed (Month, Day, Year) MAY 15, 1999																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric C. Marshall MD UNION MEMORIAL HOSPITAL																										
31. Date filed (Month, Day, Year) MAY 19 1999				32. Registrar's Signature B. Sparks																						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16089

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary E. Clautice

2. Date of Death

Month  
MAYDay  
17Year  
1999

3. Time of Death

11:20 a.m.

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

213-68-1988

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 16, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2300 Dulaney Valley Road

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Raymond H. Murgatroyd

18. Mother's Name (First, Middle, Maiden Surname)

Birdie A. Lookingland

19a. Informant's Name/Relationship (Type, Print)

Mrs. Shirley Rider (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10313 Greenside Drive Cockeysville, Maryland 21030

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Moreland Memorial Park

Date

5/20/1999

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md.

Physician  
/Medical  
Examiner23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Aspiration pneumonia

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

D52197

29d. Date signed (Month, Day, Year)

5-18-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rekha Motagi, M.D. GBMC 6701 N. Charles St, Baltimore MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

Mary Clautice

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AA3

W. J. Clapper

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ANNABELLE CRAWLEY</b>				2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>99</b>		3. Time of Death <b>11:12 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
5. Social Security Number <b>216 16 4768</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth <b>06/06/1910</b>	9. Birthplace (State or Foreign Country) <b>VA</b>
Usual Residence of Decedent							
10e. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>827 N. BENTALOU ST.</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>		16b. Kind of Business/Industry <b>BALTO. CITY SCHOOL SYS.</b>	
17. Father's Name (First, Middle, Last) <b>RALPH STOKES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HELEN EPPS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>EDGAR CRAWLEY, SR./SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6613 EBERLE DR. BALTIMORE, MD. 21215</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEDAR HILL CEMETERY</b>		Date <b>5/21/99</b>		20c. Location - City or Town, State <b>BALTO., MD</b>	
21. Signature of Funeral Service Licensee <i>James A. Morton</i>				22. Name and Address of Facility <b>JAMES A. MORTON &amp; SONS F.H., INC. 1701 LAURENS ST. BALTO., MD. 21217</b>			

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ADULT RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of): <b>b. SEPSIS</b> Due to (or as a consequence of): <b>c. PNEUMONIA</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Edward Obazee</i>		29c. License number <b>D41430</b>		29d. Date signed (Month, Day, Year) <b>MAY 17TH 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>EDWARD OBAZEE 821 NORTH EUTAW ST #407 BALTIMORE MD 21201</b>					
31. Date filed (Month, Day, Year) <b>MAY 18 1999</b>		32. Registrar's Signature <i>B. Sparks</i>			

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report  
describes the general situation  
of the country and the  
state of the economy.  
It also mentions the  
main problems of the  
country.

2. The second part of the report



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16091

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES ROBERT COMBS				2. Date of Death Month Day Year MAY 13, 1999		3. Time of Death 6:05 P.M.	
	4a. Facility Name (If not institution, give street and number) CHESAPEAKE HOSPICE HOUSE				4b. City, Town, or Location of Death LINTHICUM		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 244.38.9334		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) 11/14/1929	
	9. Birthplace (State or Foreign Country) N. CAROLINA		10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14 MCGUIRK DRIVE		10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSEMBLY LINE		16b. Kind of Business/Industry GENERAL MOTORS		17. Father's Name (First, Middle, Last) WILLIAM L. COMBS	
	18. Mother's Name (First, Middle, Maiden Surname) CARRIE MAE LAMBERT		19a. Informant's Name/Relationship (Type, Print) DEBRA K. EIDES - DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 346 HUNNER DR., PASADENA, MD 21122		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) HUNTINGDON MEMORIAL		20c. Location - City or Town, State HUNTINGDON, PENNSYLVANIA		21. Signature of Funeral Service Licensee KELLY GREGORY FINK		22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061	
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Massive Stroke Due to (or as a consequence of): Vascular Insufficiency to Brain Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Robert B. Kroopnick		29c. License number D14753		29d. Date signed (Month, Day, Year) 5/14/99	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kroopnick Aquahart road, Glen Burnie Md 21061		31. Date filed (Month, Day, Year) MAY 18 1999		32. Registrar's Signature Benjamin B. Sparks			

ORIGINAL





**Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.**

RICHARD

State of Maryland / Department of Health and Mental Hygiene

COHEN ITEMS: #23, 26, 27 PER MEO G771 5-18-99 WR.

## Certificate of Death

Reg. No. \_\_\_\_\_

99 16092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) RICHARD ALAN COHEN

2. Date of Death Month Day Year APRIL 27, 1999

3. Time of Death 7:44P.M.

4a. Facility Name (If not institution, give street and number) 1001 FELLE STREET

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death N/A

5. Social Security Number 216-42-6843

6. Sex 1X M 20 F

7. Age (In yrs. last birthday) 54 Yrs.

8. Date of Birth (Month, Day, Year) NOV. 15, 1944

9. Birthplace (State or Foreign Country) MD

10a. State MD

10b. County BALTIMORE

10c. City, Town or Location BALTIMORE

10d. Inside City Limits 10 Yes 2X No

10e. Street and Number 7922 IVY LANE

10f. Zip Code 21208

10g. Citizen of What Country? U.S.A.

11. Marital Status 10 Never Married 20 Married 30 Widowed 4X Divorced

12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 2X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROPRIETOR

16b. Kind of Business/Industry COMPUTER

17. Father's Name (First, Middle, Last) MORRIS COHEN

18. Mother's Name (First, Middle, Maiden Surname) MILLICENT WEINBERG

19a. Informant's Name/Relationship (Type, Print) DR. EDWARD COHEN / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1901 BELFAST ROAD - SPARKS, MD 21152

20a. Method of Disposition 1X Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE EMUNAH AITZ CHAIM

20c. Date 4/29/99

20d. Location - City or Town, State BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 10 Yes 2X No 30 Probably 40 Unknown

24a. Was an autopsy performed? 1X Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death? 1X Yes 20 No

25. Was case referred to medical examiner? 1X Yes 20 No

26. Place of Death (Check only one) Hospital: 10 Inpatient 20 EROutpatient 30 DOA Other: 40 Nursing Home 5X Residence 6X Other (Specify) AT SCENE

27. Manner of Death 1X Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) APRIL 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. W. W. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) MAY 10, 1999

32. Registrar's Signature

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16093

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEONARD DAVIS JR

2. Date of Death

Month Day Year  
MAY 15 1999

3. Time of Death

0116

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-78-6685

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAR 21 1960

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4809 SNADER AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HANDYMAN

16b. Kind of Business/Industry

HOME IMPROVEMENT

17. Father's Name (First, Middle, Last)

LEONARD DAVIS SR

18. Mother's Name (First, Middle, Maiden Surname)

MARY ROSS

19a. Informant's Name/Relationship (Type, Print)

Leonard Davis Sr./Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2935 Rosalind Avenue Baltimore, Maryland 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK

Date

5-21-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA  
1206 W NORTH AVENUEPhysician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Upper GI Bleed

Due to (or as a consequence of):

40 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Esophageal Varices

Due to (or as a consequence of):

months

c. Cirrhosis of liver

Due to (or as a consequence of):

years

d. alcohol abuse

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0021730

29d. Date signed (Month, Day, Year)

MAY 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tariq Khan, MD 2461 W. Belvedere Ave. Balto, MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16094

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Randella Duncan</b>				2. Date of Death Month <b>May</b> Day <b>17</b> Year <b>1999</b>				3. Time of Death <b>12:03</b>			
	4a. Facility Name (If not Institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>NA</b>			
Funeral Director	5. Social Security Number <b>212-76-2734</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>28</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-25-70</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent				10a. State <b>MD</b>				10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No				10e. Street and Number <b>1508 East 28th Street</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>X</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>in home</b>			
	17. Father's Name (First, Middle, Last) <b>Randolph Duncan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Earline Thompson</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Earline Thompson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1200 Bonaparte Avenue Baltimore, Maryland 21218</b>							
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cemetery 05-22-99 Baltimore, MD.</b>				20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>							
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumocystis Pneumonia</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>2 weeks</b>			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>b.</b> Due to (or as a consequence of):											
	<b>c.</b> Due to (or as a consequence of):											
<b>d.</b> Due to (or as a consequence of):												
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acquired Immune Deficiency Syndrome</b>								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown			
									24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No			
									24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
	27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
					28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>P12565</b>		29d. Date signed (Month, Day, Year) <b>May 17, 1999</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Anthony J. Calcutania MD Union Memorial Hospital</b>											
	31. Date filed (Month, Day, Year) <b>MAY 18 1999</b>				32. Registrar's Signature <i>[Signature]</i>							





B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

KIRK G. DELEN

State of Maryland / Department of Health and Mental Hygiene

89 16095

Amended Items #1,23,27,28.a,b,c,d,e,f,G771,5/24/99dhb

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kurt G. Delen</b> KURT GUSTAV DELEN						2. Date of Death Month Day Year <b>MAY 15, 1999</b>		3. Time of Death <b>0300 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>11 LIBERTY PARKWAY</b>						4b. City, Town, or Location of Death <b>DUNDALK</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-92-2100</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 4, 1963</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>11 Liberty Parkway</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>Automobile</b>			
17. Father's Name (First, Middle, Last) <b>Bill Delen</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Laura Borsukiewicz</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lisa Delen /sister</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14 Liberty Parkway Baltimore, MD 21222</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>			Date <b>May 19 1999</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>		
21. Signature of Funeral Service Licensee <b>Anthony C. Connolly</b>						22. Name and Address of Facility <b>Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Narcotic and cocaine intoxication</b>  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) <b>5/15/99</b>		28b. Time of Injury <b>unknown M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>unknown</b>	
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) <b>Home</b>			28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>11 Liberty Pkwy., Dundalk, MD</b>							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Dean Wolfe MD</b>						29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>MAY 15, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. CARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>MAY 18 1999</b>			32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16096

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY ERSHLER</b>		2. Date of Death Month <b>May</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>10:10 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>220-07-8326</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>NOV 4, 1918</b>		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>3647 GLENGYLE AVE., APT. 3-B</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PURCHASING MANAGER</b>		16b. Kind of Business/Industry <b>SHIP BUILDING</b>
17. Father's Name (First, Middle, Last) <b>ELIAS BERNARD ERSHLER</b>			18. Mother's Name (First, Middle, Maiden Summa) <b>FANNIE SCHNITZER</b>		
19a. Informant's Name/Relationship (Type, Print) <b>MRS. GLORIA ERSHLER (WIFE)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3647 GLENGYLE AVE., APT. 3-B BALTO., MD 21215</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MIKRO KODESH BETH ISRAEL</b>		20c. Location - City or Town, State <b>5/16/99 BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <b>Klebsiella Sepsis</b> Dua to (or as a consequence of):					
b. <b>Klebsiella pneumonia</b> Dua to (or as a consequence of):					
c. Dua to (or as a consequence of):					
d. Dua to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<b>Pancreatic Cancer metastatic to the liver</b>					
<b>Coronary Artery Disease</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>P12304</b>		29d. Date signed (Month, Day, Year) <b>May 13, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Kathryn G. Barnard, MD Sinai Hospital of Baltimore</b>					
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>			

Patient known as Harry Ershler

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

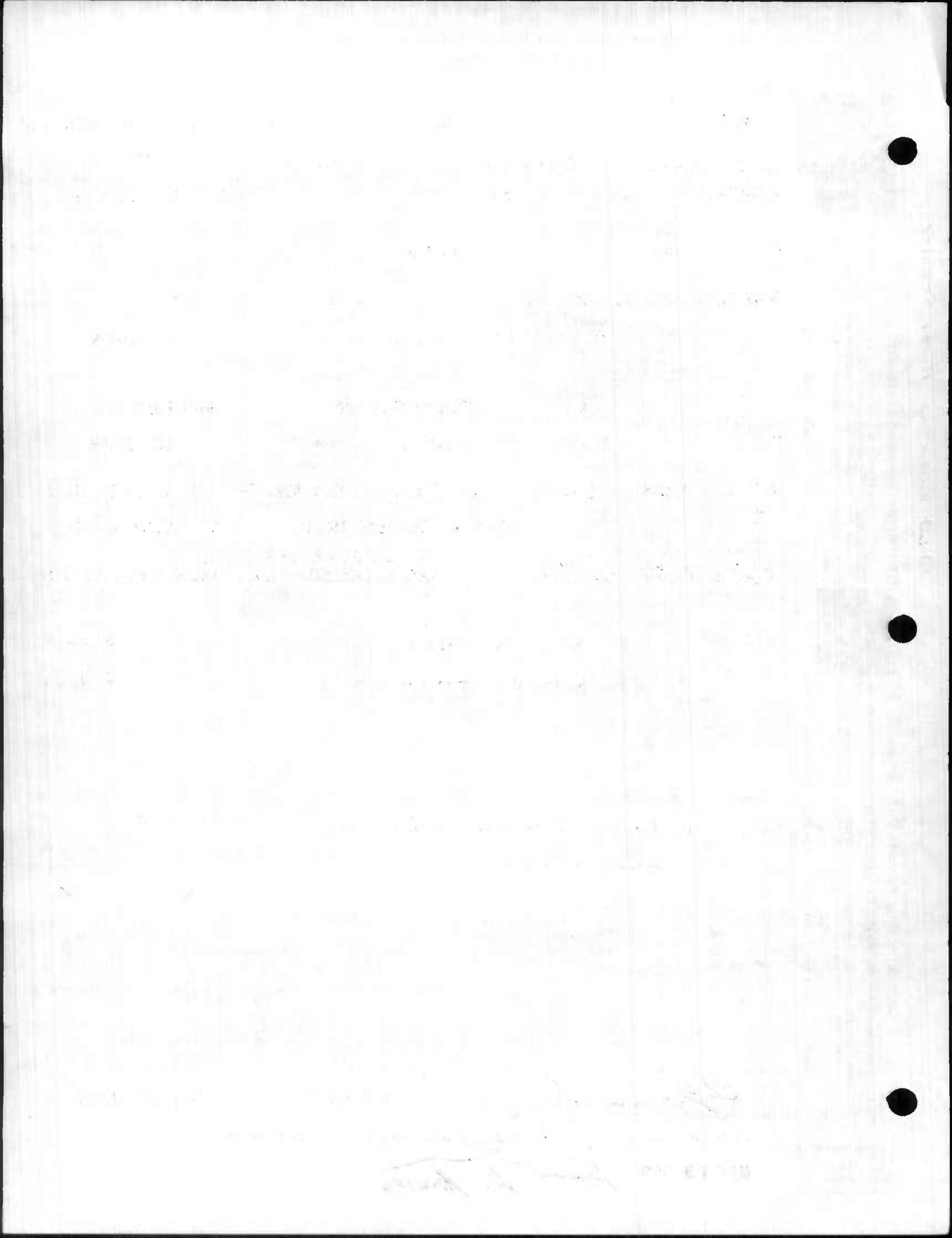
To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS:#27, 28A-F PER MEO G7715-18-99 WR.

Certificate of Death

Reg. No.

99 16097

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) JOANN LEE EASTERBROOK				2. Date of Death Month Day Year MARCH 25, 1999		3. Time of Death 1145 a.m.	
4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Calvert County		4c. County of Death Calvert	
5. Social Security Number 226-86-2886		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) 9/27/56	
9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Ann Arundel		10c. City, Town or Location Chesapeake Beach	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 605A Alabama Ave.		10f. Zip Code		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Joseph B. Moon				18. Mother's Name (First, Middle, Maiden Surname) Sara Lee			
19a. Informant's Name/Relationship (Type, Print) Douglas Easterbrook/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605A Alabama Ave. Chesapeake Beach, MD			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Memorial Park		20c. Date 3/29/99		20d. Location - City or Town, State Falls Church, VA	
21. Signature of Funeral Service Licensee				22. Name and Address of Facility National Funeral Home 7482 Lee Hwy. Falls Church, VA 22042			

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Severely Hypoxic encephalopathy Due to (or as a consequence of): Drug overdose Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) MARCH 9, 1999		28b. Time of Injury UNKNOWN M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred UNKNOWN		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HOME		28f. Location (Street and Number or Rural Route Number, City or Town, State) 605 A. ALABAMA AVE ANNE ARUNDEL CO. MD			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier K. Yazdani		29c. License number D17168		29d. Date signed (Month, Day, Year) March 26, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. K. Yazdani, M.D. 100 Hospital Road Prince Frederick, MD 20678							
31. Date filed (Month, Day, Year) MAY 18 1999		32. Registrar's Signature B. Sparks					

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ALPHA FLECKENSTEIN

2. Date of Death

May 17 1999

3. Time of Death

8:40 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

609 Dunkirk Rd.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

220-10-8935

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 23, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

609 Dunkirk Rd.

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Piper

19. Informant's Name/Relationship (Type, Print)

Paula Steese Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

609 Dunkirk Rd. Baltimore, Maryland 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Tabor Cemetery

Date

5/20/99

20c. Location - City or Town, State

OLD TOWN, Maryland

21. Signature of Funeral Service Licensee

Robert M. Knatz

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.  
6500 York Rd. Balto. Md. 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Hypertensive Cardiovascular Disease  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Alan Baldanza

29c. License number

D19166

29d. Date signed (Month, Day, Year)

5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Alan Baldanza MD 10629 York Rd. Cockeysville, Maryland 21030

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



1947. 8. 24. 200. 11. 11.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16099

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID R. FOSTER JR.</b>				2. Date of Death Month Day Year <b>MAY 17, 1999</b>		3. Time of Death <b>1200 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>SHOCK TRAUMA CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>			
Funeral Director	5. Social Security Number <b>215-72-1790</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>54 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month Day Year <b>3/28/1945</b>	9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>619 N. Calhoun St.</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>AFRICAN AMERICAN</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Janitor</b>			16b. Kind of Business/Industry <b>Cleaning</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>DAVE FOSTER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LOTTIE FOSTER</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>SPOUSE</b> <b>PATRICIA FOSTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3902 OAKFORD AVE. BALTO. MD 21215</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 5229 Randallstown, MD</b>		20c. Location - City or Town, State		20d. Date			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Albert P. Wylie F/H PA</b> <b>638 N. Gilman St. BALTIMORE, MD 21217</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Stab Wounded Neck</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
State Registrar	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>5/17/99</b>		28b. Time of Injury <b>1:20 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject Stabbed</b>	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Calhoun Street Baltimore Maryland</b>							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 18, 1999</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODOR M. KING 111 Penn Street, Baltimore, Maryland 21201</b>									
	31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten notes, mostly illegible due to fading. A single curved line is visible in the middle left section.

Handwritten text, possibly a date or a short phrase, centered in the middle of the page.

Handwritten notes at the bottom of the page, including a signature and the printed text "REPT. BY YAM".

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMENDED #26 &amp; #30PPER MD G771 5/19/99 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEIGH

GEARY

2. Date of Death

MAY 6, 1999

3. Time of Death

12:06 PM

4a. Facility Name (If not institution, give street and number)

53 TAHOE CIRCLE - APT. F

4b. City, Town, or Location of Death

OWINGS MILLS

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

218-28-3466

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 7, 1929

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

53 TAHOE CIRCLE - APT. F

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

WRITER

17. Father's Name (First, Middle, Last)

ELI

18. Mother's Name (First, Middle, Maiden Surname)

SHERMAN

ANNE

LEVIN

19a. Informant's Name/Relationship (Type, Print)

DONALD GEARY / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

53 TAHOE CIRCLE - APT. F - OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLTOP SERVICE CORP.

Date

5/7/99

20c. Location - City or Town, State

TOWSON, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Rectal Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days  
73 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H43157

29d. Date signed (Month, Day, Year)

5/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TYLER CHILDS CYMET, M.D. 5101 Lanier Ave. Balto., MD 21215; OSTEOPATHIC ASSOC. INC

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16101

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Marie R. Giannino</b>				2. Date of Death Month Day Year <b>MAY 13 1999</b>		3. Time of Death <b>5:05PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>8015 Caradoc Dr.</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>212-26-1503</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b>		8. Date of Birth (Month, Day, Year) <b>11-12-28</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Rosedale</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>8015 Caradoc Dr.</b>		10f. Zip Code <b>21237</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Receptionist</b>		16b. Kind of Business/Industry <b>Essex Comm. Col.</b>					
17. Father's Name (First, Middle, Last) <b>Guiseppe Caccamise</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jennie Garbo</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Philip E. Giannino/husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8015 Caradoc Dr. Rosedale, MD 21237</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		Date <b>5-17-99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>			
21. Signature of Funeral Service Licensee <i>Denise S. Kelly</i>				22. Name and Address of Facility <b>Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>LIVER FAILURE</b> Due to (or as a consequence of): b. <b>METASTATIC DISEASE OF THE LIVER</b> Due to (or as a consequence of): c. <b>SQUAMOUS CELL CARCINOMA OF VOCAL CORD</b> Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death  <b>3 week</b> <b>6 mo</b> <b>18 mo</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Daniel P. Zygmunt MD</i>		29c. License number <b>D17996</b>		29d. Date signed (Month, Day, Year) <b>MAY 13, 1999</b>			
30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>DAVID P. ZAJANOWSKI - STE 205 9101 FRANKLIN SQUARE DR, BALTIMORE MD 21237</b>									
31. Date filed (Month, Day, Year) <b>MAY 18 1999</b>		32. Registrar's Signature <i>Kenneth G. Sparks</i>							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16102

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LOUISE GLAZER</b>				2. Date of Death Month <b>May</b> Day <b>11</b> Year <b>1999</b>		3. Time of Death <b>8:35 PM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore, MD</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>212-18-5959</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC. 27 1919</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>6711 PARK HEIGHTS AVE.</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>+4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>EXECUTIVE SECRETARY</b>			16b. Kind of Business/Industry <b>BALTO. HEBREW TEMPLE</b>		
17. Father's Name (First, Middle, Last) <b>BERNARD MERFELD</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HILDA FISHER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MRS. PHYLLIS LEDERMAN (DAUG.)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6815 PIMLICO DR. BALTO., MD 21209</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW</b>		Date <b>5/13/99</b>		20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>			
21. Signature of Funeral Service Licensee <i>Sutton Gutter</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. metastatic lung cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28e. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Resident physician</i>		29c. License number <b>P12343</b>		29d. Date signed (Month, Day, Year) <b>May 11, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joel Walker, M.D. Sinai Hospital Baltimore MD 21215</b>									
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <i>B. Spaulding</i>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

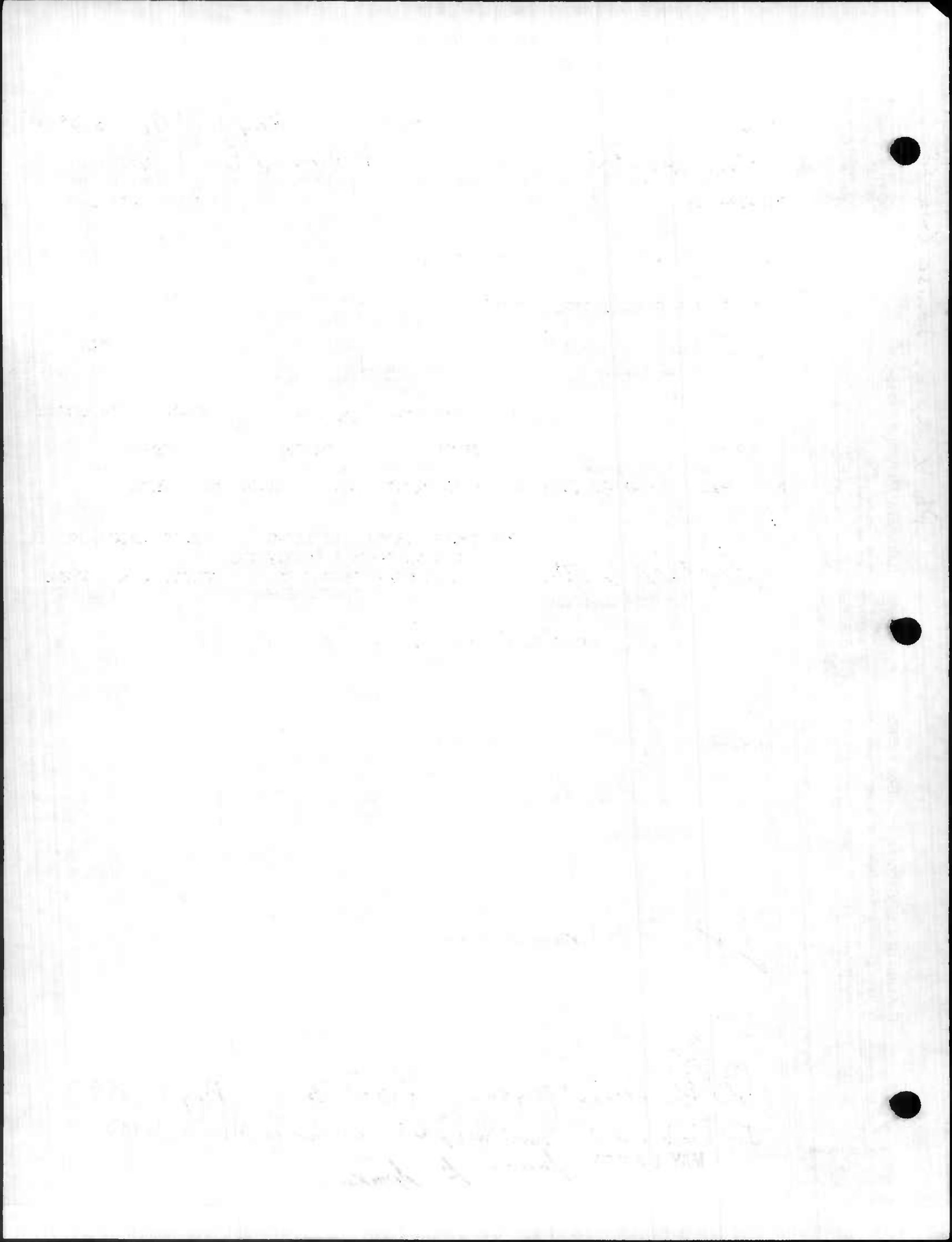
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.




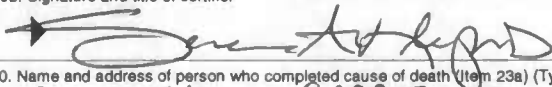

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 16103

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Opal G. Hoffman</b>				2. Date of Death Month <b>May</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>8:45AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>233-32-0966</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 30, 1917</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1118 Stephen Drive</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Records Tech.</b>			16b. Kind of Business/Industry <b>Hospital</b>	
17. Father's Name (First, Middle, Last) <b>Robert Burns George</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ollie Christian</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Brenda Smith (daughter)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1118 Stephen Drive, Baltimore, Maryland 21220</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens</b>		Date <b>5/19/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. End Stage Chronic Obstructive Pulmonary Disease - 2 Years</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart Failure, Hypertension</b>							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>RD 187161</b>		29d. Date signed (Month, Day, Year) <b>May 17, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Serena Klugh 9000 Franklin Square Drive Baltimore, MD 21237</b>								
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 						

Hoffman, Opal  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4110



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16104

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHRISTIAN GUSTAV HAGEN, Jr.</b>		2. Date of Death Month Day Year <b>May 16, 1999</b>		3. Time of Death <b>6:20 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Dulaney Towson Nursing Home</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>213-07-7013</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sept. 28, 1913</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>4300 Southfield Dr.</b>			10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Bethlehem Steel</b>	
17. Father's Name (First, Middle, Last) <b>Christian G. Hagen, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anna L. Fahey</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Helen D. Hagen/wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4300 Southfield Dr. Baltimore, Md. 21236</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial</b>		20c. Location - City or Town, State <b>5/20/99 Timonium, Md.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Aspiration Pneumonia</b> Due to (or as a consequence of): <b>b. Parkinson's Disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death <b>5 days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and Title of Certifier 		29c. License number <b>D34124</b>		29d. Date signed (Month, Day, Year) <b>5-17-99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John D. Miller, M.D. 1205 York Rd #20 Lutherville, Md 21093</b>					
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gwendolyn L. Hamlin

2. Date of Death

Month

Day

3. Time of Death

4b. City, Town, or Location of Death

4c. County of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

Baltimore

N/A

5. Social Security Number

220-22-8345

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 24, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

10b. County

Maryland

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2832 Riggs Ave.

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Lutheran Hosp.

17. Father's Name (First, Middle, Last)

George Timberlake

18. Mother's Name (First, Middle, Maiden Surname)

Reese Johnson

19a. Informant's Name/Relationship (Type, Print)

Mr. Derwin L. Hamlin (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2832 Riggs Ave. Balto, Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest

Date

5/20/99

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

3 DAYS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

T. MEHRA MD

29c. License number

P-10883

29d. Date signed (Month, Day, Year)

MAY 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. MEHRA, 900 CATON AVE., BALTIMORE, MD

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME

Hamlin, Gwendolyn

Division of Vital Records, P.O. Box 68760,





100-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


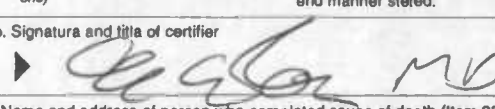

State of Maryland / Department of Health and Mental Hygiene

Amended Item 19b per FH,G771,05/19/99dhb

## Certificate of Death

Reg. No.

99 16106

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OSCAR</b>				2. Date of Death Month <b>MAY</b> Day <b>13</b> Year <b>1999</b>				3. Time of Death <b>3:15PM</b>																																		
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>																																		
Funeral Director	5. Social Security Number <b>214-34-3484</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>94</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 25 1905</b>		9. Birthplace (State or Foreign Country) <b>POLAND</b>																																		
	Usual Residence of Decedent																																										
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																			
10e. Street and Number <b>3737 CLARKS LA., APT. 404</b>				10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>USA</b>																																			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>																																			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER</b>				16b. Kind of Business/Industry <b>BAKERY</b>																																			
17. Father's Name (First, Middle, Last) <b>SIMON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARAH</b>																																							
19a. Informant's Name/Relationship (Type, Print) <b>CHARLES HOLZMAN (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2419 FOREST GREEN RD. BALTIMORE, MD 21209</b>																																							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TIFEREITH ISRAEL ANSHE SFARD</b>				20c. Location - City or Town, State <b>ROSEDALE, MD</b>																																			
21. Signature of Funeral Service Licensed 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>																																							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																											
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td colspan="7">Myocardial Infarction</td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>2 minutes</b> </td> </tr> <tr> <td>b.</td> <td colspan="7">GI Bleed</td> </tr> <tr> <td>c.</td> <td colspan="7"></td> </tr> <tr> <td>d.</td> <td colspan="7"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Myocardial Infarction							Approximate Interval Between Onset and Death  <b>2 minutes</b>	b.	GI Bleed							c.								d.							
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Myocardial Infarction							Approximate Interval Between Onset and Death  <b>2 minutes</b>																																		
	b.	GI Bleed																																									
	c.																																										
	d.																																										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																																			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number <b>D36928</b>		29d. Date signed (Month, Day, Year) <b>5/14/99</b>																																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan A. ROSEN MD 222 W. Cold Spring BALT MD 21210</b>																																											
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 																																									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

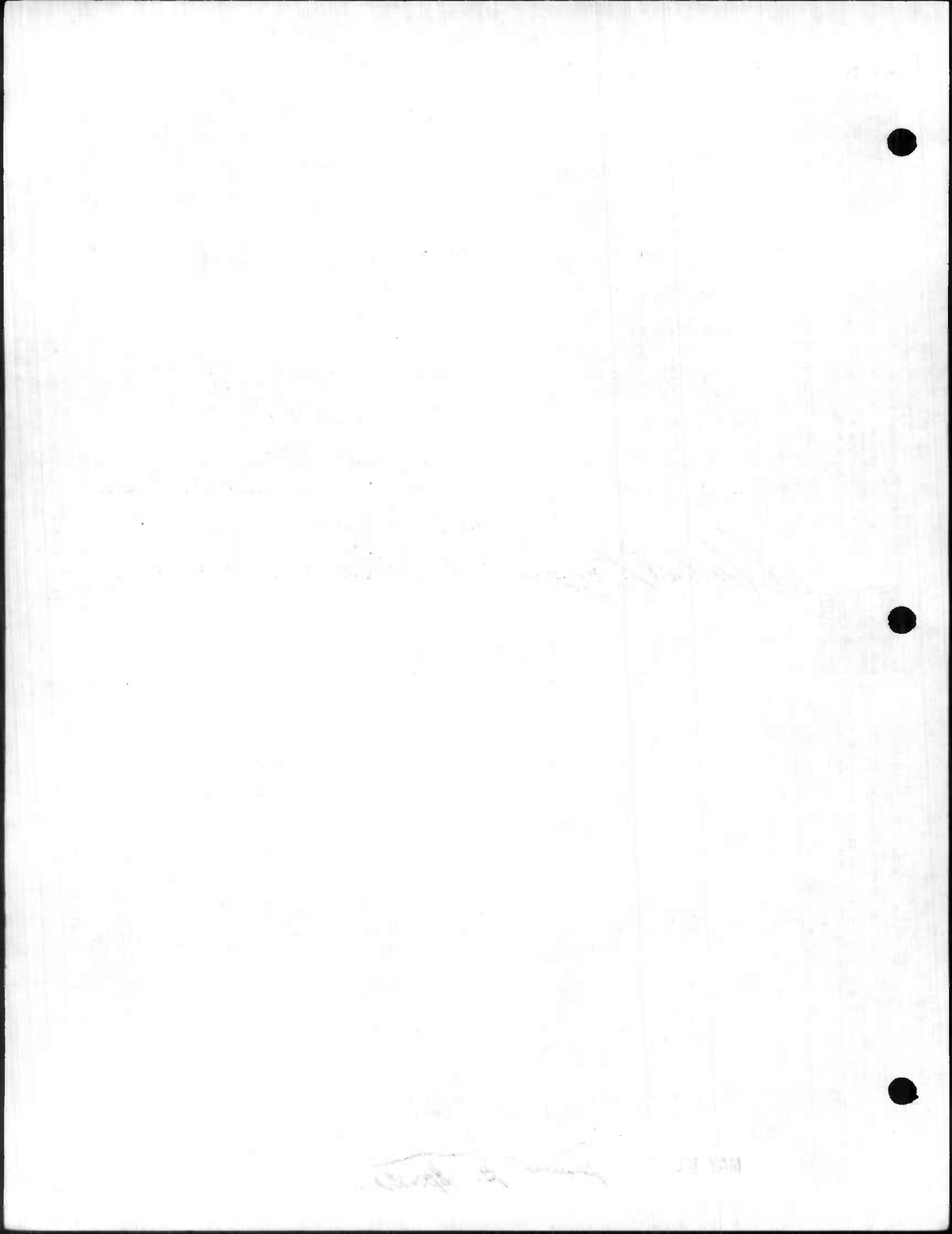
State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



## Certificate of Death

Reg. No.

99 16107

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Edward Hawkins, Jr.				2. Date of Death Month Day Year May 16, 1999		3. Time of Death 10:59 A.M.		
	4a. Facility Name (If not institution, give street and number) 2823 North Howard Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 217-11-9114		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 26 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 20 1973		
	9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent									
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2823 North Howard Street				10f. Zip Code 21218		10g. Citizen of What Country? United States			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Persian Gulf		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Guard			16b. Kind of Business/Industry Security		
17. Father's Name (First, Middle, Last) Charles Edward Hawkins, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Susan Karen Strejcek					
19a. Informant's Name/Relationship (Type, Print) Charles E. Hawkins, Sr./Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310-A Garden Road Towson, Maryland 21286					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns.		Date 5/20/99		20c. Location - City or Town, State Timonium, Maryland			
21. Signature of Funeral Service Licensee Steven T. Zitter				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Intra-oral shotgun wound Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23b. Did tobacco contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? Limited <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Found 5-16-99		28b. Time of Injury unknown M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot self	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence									
28f. Location (Street and Number or Rural Route Number, City or Town, State) 2823 North Howard Baltimore City, Maryland									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Stephen S. Radentz				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) May 17, 1999			
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) MAY 19 1999				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



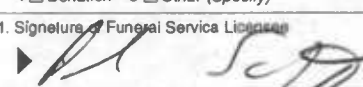
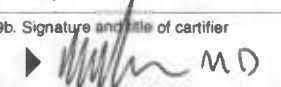
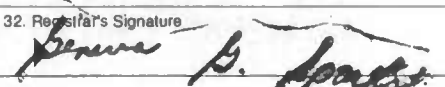
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16108

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sylvan Allan Hoffman</b>		2. Date of Death Month <b>MAY</b> Day <b>10</b> Year <b>1999</b>		3. Time of Death <b>12:58 PM</b>													
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>													
Funeral Director	5. Social Security Number <b>212-12-1824</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.													
	8. Date of Birth (Month, Day, Year) <b>SEPT. 28, 1916</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>															
Usual Residence of Decedent																		
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>OWINGS MILLS</b>														
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																		
10e. Street and Number <b>4505 BRIGHTWATER CT., APT. A</b>		10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>USA</b>														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:														
14. Race - American Indian, Black, White, etc. Specify <b>WHITE</b>																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) <b>4</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHARMACIST</b>		16b. Kind of Business/Industry <b>PHARMACY</b>														
17. Father's Name (First, Middle, Last) <b>LOUIS HOFFMAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LENA MILLER</b>																
19a. Informant's Name/Relationship (Type, Print) <b>DEBORAH HOFFMAN (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4505 BRIGHTWATER CT., APT. A OWINGS MILLS, MD 21117</b>																
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP.</b>		20c. Location - City or Town, State <b>TOWSON, MD</b>														
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>Adult Respiratory Distress Syndrome</b></td> <td>Approximate Interval Between Onset and Death <b>1 week</b></td> </tr> <tr> <td>b.</td> <td><b>Intra Abdominal Sepsis</b></td> <td><b>3 weeks</b></td> </tr> <tr> <td>c.</td> <td><b>Perforated Bowel</b></td> <td><b>3 weeks</b></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Adult Respiratory Distress Syndrome</b>	Approximate Interval Between Onset and Death <b>1 week</b>	b.	<b>Intra Abdominal Sepsis</b>	<b>3 weeks</b>	c.	<b>Perforated Bowel</b>	<b>3 weeks</b>	d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Adult Respiratory Distress Syndrome</b>	Approximate Interval Between Onset and Death <b>1 week</b>															
	b.	<b>Intra Abdominal Sepsis</b>	<b>3 weeks</b>															
	c.	<b>Perforated Bowel</b>	<b>3 weeks</b>															
	d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>														
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. Signature and title of certifier  M.D.		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>MAY 10 1999</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael FAULKNER 600 North Wolfe Street Baltimore, MD 21287-9106</b>																		
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEMS: #26 PER MD G771 5-19-99 WR.

## Certificate of Death

Reg. No.

99 16109

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lena Jane Hull</b>		2. Date of Death Month Day Year <b>May 16, 1999</b>		3. Time of Death <b>2:00 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>311 Forest Valley Drive</b>		4b. City, Town, or Location of Death <b>Forest Hill</b>		4c. County of Death <b>Harford</b>
Funeral Director	5. Social Security Number <b>217-34-3793</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>April 2, 1917</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>137 Ventnor Terrace</b>		10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 Years</b> College (14 or 5+) <b>College</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Calvin Cowan</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Huldah Vaughn</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Son</b> <b>Mr. Raymond A. Hull, Jr.</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>311 Forest Valley Drive Forest Hill, MD 21050</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Pk. 5/19/1999</b>		20c. Location - City or Town, State <b>Elkridge, Maryland</b>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Ave. Dundalk, Maryland 21222</b>		
	23a. Part I. Enter the disease, or complications that caused the death; shock, or heart failure. List only one cause on each line. <b>Lung Cancer with Metastases</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate interval Between Onset and Death <b>8 months</b>
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D44793</b>		29d. Date signed (Month, Day, Year) <b>5/17/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Ali Samad 6730 Holabird Ave Balto md 21220</b>					
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16110

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Orville Edward Hood				2. Date of Death Month Day Year May 16, 1999		3. Time of Death 8:15 pm	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 494-16-4940		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 03/09/1916	
	9. Birthplace (State or Foreign Country) Missouri							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 5003 Pilgrim Road				10f. Zip Code 21214		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1936-39		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John W. Hood				18. Mother's Name (First, Middle, Maiden Surname) Minnie K. Garner			
	19a. Informant's Name/Relationship (Type, Print) Catherine N. Hood/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5003 Pilgrim Road, Baltimore, Maryland 21214			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gdns		Date 5/20/99		20c. Location - City or Town, State Timonium, Maryland	
	21. Signature of Funeral Service Licensee Christina L. David				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. Sepsis Due to (or as a consequence of): b. Urinary Tract infection Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Diabetes Mellitis						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Michael Hieb MD				29c. License number P11931		29d. Date signed (Month, Day, Year) May 16, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Hieb Sinai Hospital								
31. Date filed (Month, Day, Year) MAY 19 1999		32. Registrar's Signature B. Sparks						

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16111

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mark Edward Iacovelli				2. Date of Death Month Day Year May 16, 1999		3. Time of Death 3:40 PM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-58-4936		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 19, 1952	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Edgemere	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 7710 North Point Creek Road				10f. Zip Code 21219		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Engineer		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Frank Iacovelli, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Catherine Croucher			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Donna Iacovelli/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7710 North Point Creek Road Edgemere, MD 21219			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Date 5/18/1999		20d. Location - City or Town, State Towson, Maryland	
	21. Signature of Funeral Service Licensee <i>Patricia M. Heming</i>				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Small cell Cancer of Lung Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 8 months			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier <i>W.A. Riley</i>		29c. License number 025205		29d. Date signed (Month, Day, Year) May 16, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W.A. Riley Gbmc 6701 N. Charles St. Balto. Md 2120x								
31. Date filed (Month, Day, Year) MAY 19 1999		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nelson R. Johnston

2. Date of Death

Month

Day

Year

May

16

1999

3. Time of Death

4:25pm

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-28-3432

6. Sex

XX M 2□ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

2/01/1932

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

3807 Conduit Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2X Married  
3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1X Yes 2□ No

If Yes, Give

Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2X No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Tag Engineering;

Machine Shop

17. Father's Name (First, Middle, Last)

Edward H. Johnston

18. Mother's Name (First, Middle, Maiden Surname)

May Christine Miller

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Johnston Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3807 Conduit Avenue Baltimore, Maryland 21211

20a. Method of Disposition

X X Burial 2□ Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Memorial

Date

5/20/99

20c. Location - City or Town, State

Cockeysville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc.

3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Brain Stem CVA

Due to (or as a consequence of):

b. HTN

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

13 days

17 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia, CHF, CAD,

DM II, HTN

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2X No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?

1□ Yes 2X No

Hospital:

1X Inpatient 2□ ER/Outpatient 3□ DOA

26. Place of Death (Check only one)

Other:

4□ Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1X Natural

2□ Accident

3□ Suicide

4□ Homicide

5□ Pending investigation

6□ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Yao-Yao Zhu M.D.

29c. License number

D0053654

29d. Date signed (Month, Day, Year)

May 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YAO-YAO ZHU

Union Memorial Hospital

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

107177





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

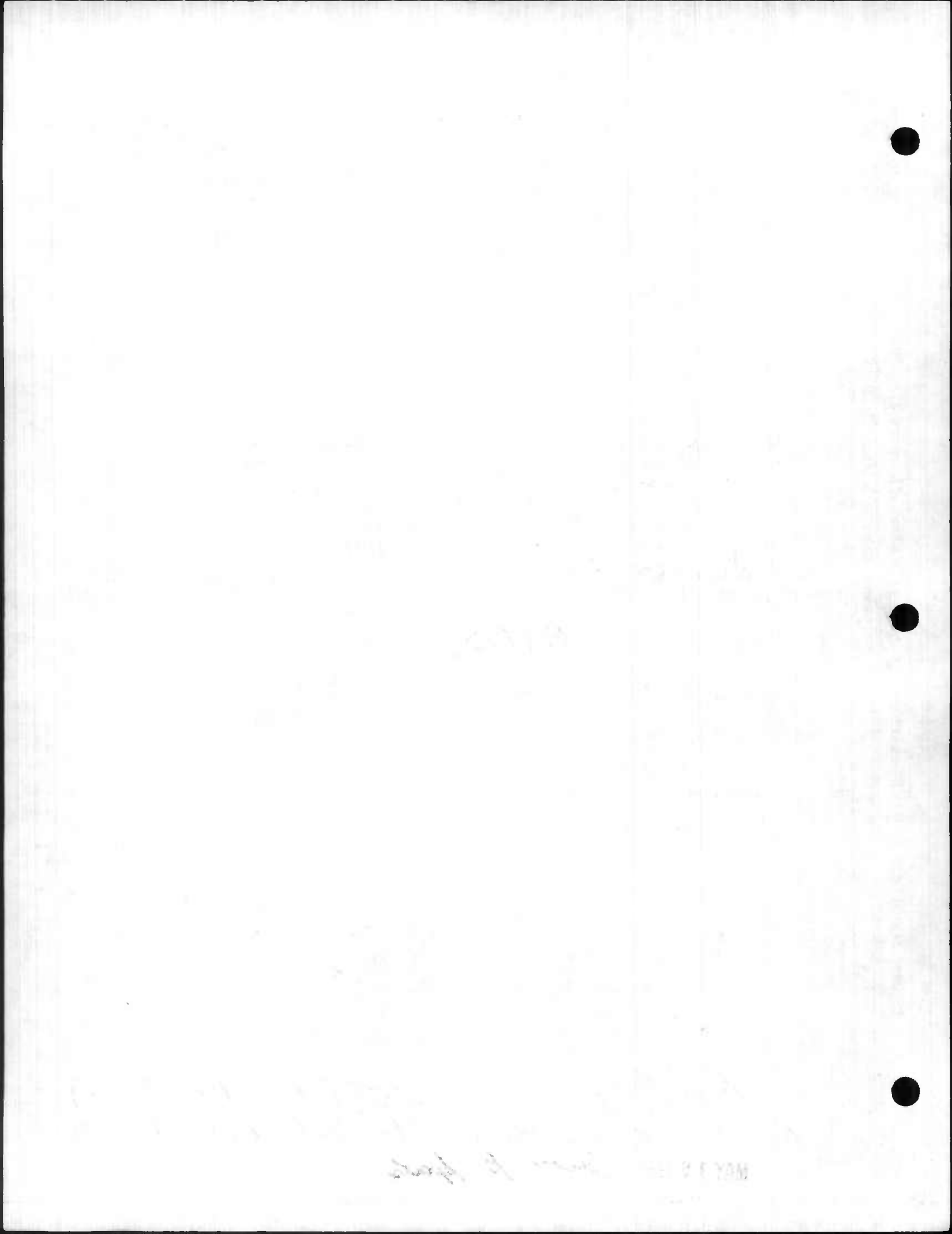
99 16113

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley A. Johnson					2. Date of Death Month Day Year 5 16 1999		3. Time of Death 2:40 a.m.			
	4a. Facility Name (If not institution, give street and number) 3715 Liberty Heights Avenue					4b. City, Town, or Location of Death Baltimore		4c. County of Death NA			
Funeral Director	5. Social Security Number 214-88-7329		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) 2-5-1972		9. Birthplace (State or Foreign Country) Md		
	Usual Residence of Decedent										
10a. State Md		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 3715 Liberty Heights Avenue					10f. Zip Code 21215		10g. Citizen of What Country? U S A				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) NA					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier			16b. Kind of Business/Industry Salvation Army			
17. Father's Name (First, Middle, Last) Willie Earl moore					18. Mother's Name (First, Middle, Maiden Surname) Geneva Johnson						
19a. Informant's Name/Relationship (Type, Print) Geneva Ayers - Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3715 liberty Heights Avenue Baltimore, Md 21215						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date 5-20-99		20c. Location - City or Town, State Anne Arundel Co, Md				
21. Signature of Funeral Service Licensee <i>Shannon Stokes</i>					22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>AIDS</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <u>Six years</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number 037928		29d. Date signed (Month, Day, Year) May 17, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert K. Kelly MD 2435 West Belvidere Ave. Baltimore MD 21215											
31. Date filed (Month, Day, Year) MAY 19 1999					32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

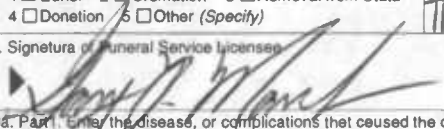
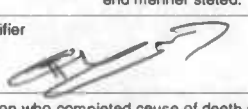
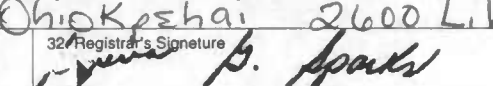


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 16114

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gertrude G. Jones</b>				2. Date of Death Month: <b>MAY</b> Day: <b>15</b> Year: <b>1999</b>		3. Time of Death <b>3:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>5216 Edmondson Ave.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>431-82-5922</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min:	8. Date of Birth (Month, Day, Year) <b>FEB. 22, 1912</b>	9. Birthplace (State or Foreign Country) <b>Mississippi</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town, or Location <b>Baltimore</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5216 Edmondson Ave.</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>3rd</b> College (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farm Owner</b>			16b. Kind of Business/Industry <b>Farming</b>		
17. Father's Name (First, Middle, Last) <b>Harvey George</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethole Clark</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rev. Matthew Jones</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>601 Aldershot Rd. Baltimore, MD. 21229</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Thompson's Cemetery</b>		20c. Location - City or Town, State <b>5/30/99 Snow Lake, Arkansas</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gary D. March Funeral Home P.A. 2750 Frederick Rd. Balto., MD. 21229</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): b. <b>HYPERTENSION</b> Due to (or as a consequence of): c. <b>DEGENERATIVE JOINT DISEASE</b> Due to (or as a consequence of): d. <b>ALZHEIMERS DISEASE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D30115</b>	
				29d. Date signed (Month, Day, Year) <b>5/17/99</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Iqbaldeen Ohikeshai 2600 Liberty Hgts. Ave Baltimore MD 21215</b>									
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16115

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gerard A. Kreusinger</b>				2. Date of Death Month <b>MAY</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>3:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>214-03-3407</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 11, 1916</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4405 Buchanan Avenue</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Proprietor</b>			16b. Kind of Business/Industry <b>Oil Company</b>	
17. Father's Name (First, Middle, Last) <b>Stephen Kreusinger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Barbara Yeakel</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Carolyn Pilachowski (Niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6113 Bellinham Court Apt 1312, Baltimore, Maryland 21210</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer</b>			20c. Location - City or Town, State <b>5/17/1999 Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>UROSEPSIS</b> a. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PNEUMONIA</b> <b>PROSTATE CANCER</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier 				29c. License number <b>D 37254</b>		29d. Date signed (Month, Day, Year) <b>5/13/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BOON P. LIM, M.D., 7601 OSLER DR., TOWSON, MARYLAND 21204</b>								
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 16116

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THEODORE KLEIN</b>						2. Date of Death Month Day Year <b>MAY 11 1999</b>		3. Time of Death <b>9:10PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>						4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>219-30-8238</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR 5, 1932</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7632 CARLA RD.</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROPRIETOR</b>			16b. Kind of Business/Industry <b>SAM KLEIN &amp; SONS, INC.</b>			
17. Father's Name (First, Middle, Last) <b>SAMUEL KLEIN</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>SOPHIE SOLOWAY</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MRS. LIBBY KLEIN (WIFE)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7632 CARLA RD. BALTIMORE, MD 21208</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN</b>		Date <b>5/13/99</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>				
23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Esophageal Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 						29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>5/12/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>201-109 Back River Road Baltimore MD 21221</b>										
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEM: #3 PER MD G771 5-19-99 WR.

99 16117

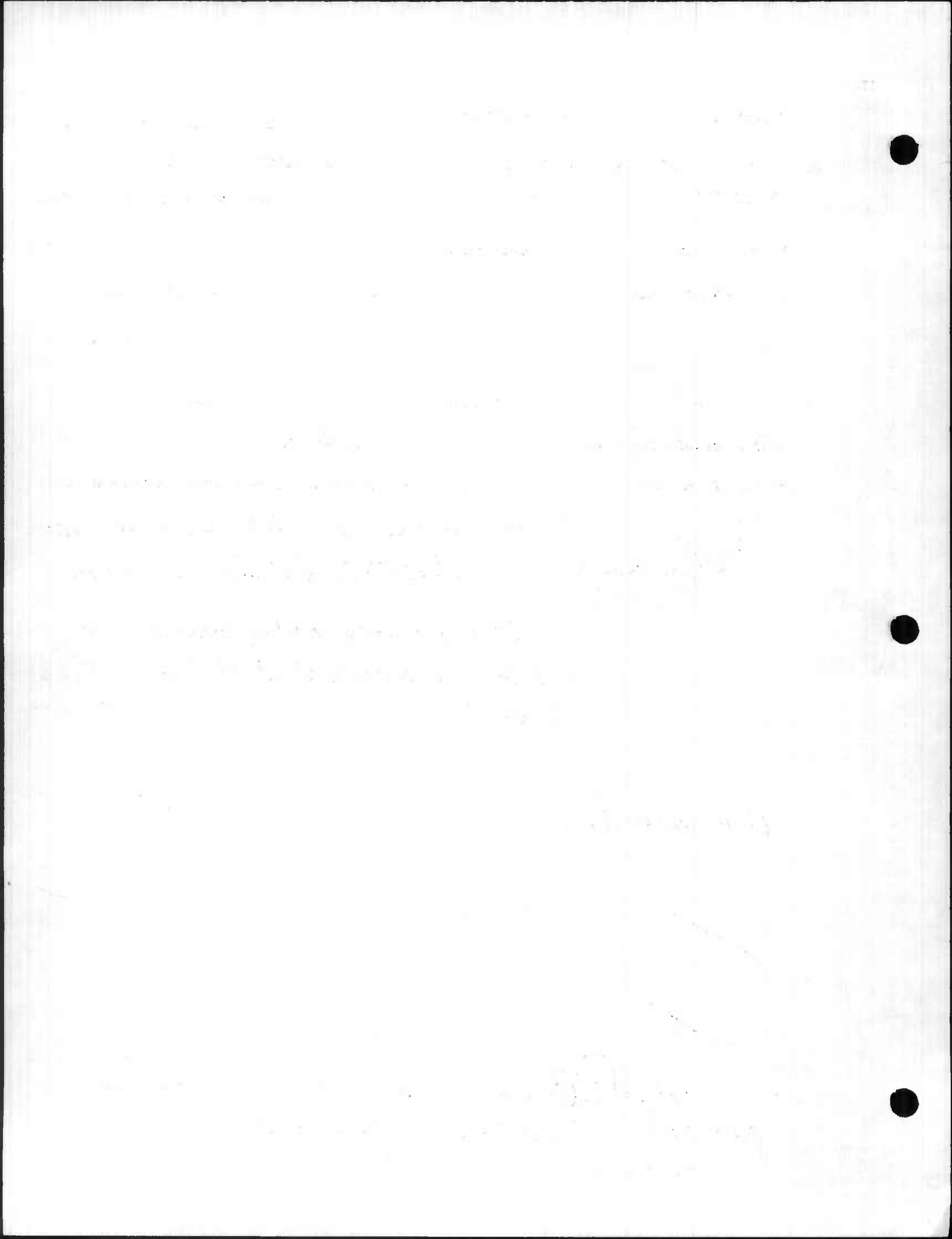
Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician / Medical Examiner  
 Funeral Director  
 To Be Completed by Funeral Director  
 Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>VIRGINIA C KOFFENBERGER</b>		2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>1415</b>	
4a. Facility Name (If not institution, give street and number) <b>KENT AND QUEEN ANNE'S HOSPITAL</b>		4b. City, Town, or Location of Death <b>CHESTERTOWN</b>		4c. County of Death <b>KENT</b>	
5. Social Security Number <b>022-20-9279</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>Sept. 24, 1910</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>			
10a. State <b>Maryland</b>		10b. County <b>Kent</b>		10c. City, Town or Location <b>Chestertown</b>	
10e. Street and Number <b>319 Woodduck Lane</b>		10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>		16b. Kind of Business/Industry <b>Retail</b>	
17. Father's Name (First, Middle, Last) <b>Wilbur Brandt Ferguson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie Poe</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Wilbur Isner/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1208 Broadview Blvd., Glen Burnie, Maryland 21061</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061</b>			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>CAD Coronary Artery Disease</b> Due to (or as a consequence of): <b>CHF Congestive Heart Failure</b> Due to (or as a consequence of): <b>Diabetes</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>Sys</b> <b>Sys</b> <b>may years</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinsonism</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D36054</b>		29d. Date signed (Month, Day, Year) <b>5/14/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>120 SREEN ROAD CHESTERTOWN MD</b>					
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <b>B. Sparks</b>			

AA 6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DAVID KAHAN</b>			2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>1999</b>		3. Time of Death <b>12:27AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOSPICE OF BALTIMORE - GILCHRIST CENTER</b>			4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>348-46-6247</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Year <b>APR 6, 1955</b>
	9. Birthplace (State or Foreign Country) <b>ILLINOIS</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>MD</b>	10b. County <b>HOWARD</b>	10c. City, Town or Location <b>ELLCOTT CITY</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>10163 BRACKEN DR.</b>			10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHYSICIAN</b>		16b. Kind of Business/Industry <b>MEDICINE</b>		
	17. Father's Name (First, Middle, Last) <b>LEONARD KAHAN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>PEGGY KAUFMAN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>KRISTINA KAHAN (WIFE)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10163 BRACKEN DR. ELLCOTT CITY, MD 21042</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW</b>		Date <b>5/16/99</b>	20c. Location - City or Town, State <b>REISTERSTOWN, MD</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>			
	23a. Part I. Enter the disease, or combination of diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Non-Hodgkins Lymphoma</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>			Approximate Interval Between Onset and Death <b>6 months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29f. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>025205</b>		29d. Date signed (Month, Day, Year) <b>May 14, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley GBC 6701 N. Charles St. Balto. md 21208</b>							
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 					

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 33a or 33a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-16119

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Fred Keller</b>				2. Date of Death Month <b>MAY</b> Day <b>17</b> , Year <b>1999</b>				3. Time of Death <b>7:24 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>216-05-3663</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>05/19/1909</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Parkville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>2617 Proctor Lane</b>				10f. Zip Code <b>21234</b>				10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Letter Carrier</b>				16b. Kind of Business/Industry <b>Postal Service</b>			
17. Father's Name (First, Middle, Last) <b>Fred Keller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Fertig</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Bernadine A. Keller/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2617 Proctor Lane, Parkville, Maryland 21234</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer</b>		Date <b>05/20/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>					
21. Signature of Funeral Service Licensee <b>Christina L. David</b>				22. Name and Address of Facility <b>Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>MASSIVE MYOCARDIAL INFARCTION</b> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D37254</b>		29d. Date signed (Month, Day, Year) <b>5-18-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BOON P. LIM, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>											
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <b>[Signature]</b>									

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16120

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Warren Lewis				2. Date of Death Month Day Year May 17, 99		3. Time of Death 8:28am	
	4a. Facility Name (If not institution, give street and number) 330 East 28th Street				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 223-26-0037		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 04-12-16	
	9. Birthplace (State or Foreign Country) NC		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 330 East 28th Street		10f. Zip Code 21218		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 5th Grade NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Packer		16b. Kind of Business/Industry MacMillan Bloedel Packing Company			
	17. Father's Name (First, Middle, Last) Allen Lewis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Hattie Whitaker			
	19a. Informant's Name/Relationship (Type, Print) Margaret Elbeck				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5432 Price Avenue Baltimore, Maryland 21218			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. Date 05-21-99		20d. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Approximate Interval Between Onset and Death 5 min 10 years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D 052016		29d. Date signed (Month, Day, Year) May 18, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wael Samara, 1111 N. Calvert St. #520, Baltimore, MD 21218								
31. Date filed (Month, Day, Year) MAY 18 1999		32. Registrar's Signature 						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16121

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert

Lauer

2. Date of Death  
Month Day Year  
May 16 1999

3. Time of Death  
07:20

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

219-18-2660

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 17, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1911 Eastfield Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Pressman

16b. Kind of Business/Industry

Printing Co.

17. Father's Name (First, Middle, Last)

Williams J. Lauer

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Flynn

19a. Informant's Name/Relationship (Type, Print)

Phyllis Ostendorf/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

330 Regal Drive Abingdon, Maryland 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 5/19/1999 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

a. Due to (or as a consequence of):

Cirrhosis of the Liver

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* M.D. (Ejadi)

29c. License number

P 11305

29d. Date signed (Month, Day, Year)

May 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel Ejadi, M.D. Department of Medicine, Johns Hopkins Bay View

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16122

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Valentine John Mazan				2. Date of Death Month Day Year May 15, 1999		3. Time of Death 1:00 PM	
	4a. Facility Name (If not institution, give street and number) 7864 St. Gregory Drive				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-14-9564		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 5, 1922	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 7864 St. Gregory Drive		10f. Zip Code 21222		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Steel Industry			
	17. Father's Name (First, Middle, Last) Karol Mazan				18. Mother's Name (First, Middle, Maiden Summa) Frances Kutz			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Rita Mazan/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7864 St. Gregory Drive Dundalk, Maryland 21222			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Ht. of Jesus Cem.		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 5/19/99	
	21. Signature of Funeral Service Licensee John L. Gado		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of The Lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 7 months							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive Pulmonary Disease							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Marvin Jack Feldman MD		29c. License number D07930		29d. Date signed (Month, Day, Year) May 17, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARVIN JACK FELDMAN MD 301st Paul Pl Tower Bldg #407							
31. Date filed (Month, Day, Year) MAY 19 1999		32. Registrar's Signature P. Sparks						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16123

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Betty Morgan</b>				2. Date of Death Month Day Year <b>MAY 12 1999</b>		3. Time of Death <b>2:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>217-03-3002</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 23, 1940</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>7631 Old Battle Grove Road</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Not Known</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembler</b>			16b. Kind of Business/Industry <b>Chimes School</b>		
17. Father's Name (First, Middle, Last) <b>Irvin Morgan</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys Minnick</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Theresa L. Clements/Cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>607 Mace Ave. Essex, Maryland 21221</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		Data <b>5/19/1999</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b> <b>7922 Wise Ave. Dundalk, Maryland 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Biventricular Failure</b> Due to (or as a consequence of): b. <b>Dilated Cardiomyopathy</b> Due to (or as a consequence of): c. <b>Right Arm Thrombosis</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>36 Hours</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residencia <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>RD 189100</b>		29d. Date signed (Month, Day, Year) <b>5.12.1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr Alan Ackerman 9000 Franklin Square Drive Baltimore, MD 21237</b>									
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 							

Betty Morgan

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

AH3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16124

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>RICHARD NEWTON</u>				2. Date of Death Month <u>MAY</u> Day <u>17</u> Year <u>1999</u>		3. Time of Death <u>353pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>NORTHWEST HOSPITAL</u>				4b. City, Town, or Location of Death <u>Randallstown</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>215-14-9030</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>76</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Jan. 5, 1923</u>	9. Birthplace (State or Foreign Country) <u>Md.</u>
	Usual Residence of Decedent							
10a. State <u>Md.</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Pikesville</u>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <u>11 Church Lane</u>				10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Foster Parent</u>			16b. Kind of Business/Industry <u>City of Baltimore</u>	
17. Father's Name (First, Middle, Last) <u>Howard Vernon Newton</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Annie DOW Newton</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Lisa P. Newton Daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9612 Southall Road #4 Randallstown, Md.</u>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory</u>		Data <u>May 24</u>		20c. Location - City or Town, State <u>Owings Mills, md.</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216</u>				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death <u>4 YEARS</u>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <u>OBSTRUCTIVE AIRWAY DISEASE</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D11171</u>		29d. Date signed (Month, Day, Year) <u>MAY 17, 1999</u>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>E. P. Williams 405 Frederick Ave, CATONSVILLE, 21228 MARYLAND</u>								
31. Date filed (Month, Day, Year) <u>MAY 19 1999</u>		32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16125

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Rocca McCoy

2. Date of Death

May 14, 1999

3. Time of Death

10:40 pm

4a. Facility Name (If not institution, give street and number)

8721 Valleyfield Road

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

217-56-8845

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/15/1958

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8721 Valleyfield Road

10f. Zip Code

21093

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Registrar

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Account Manager

16b. Kind of Business/Industry

Clinical Laboratory

17. Father's Name (First, Middle, Last)

Fortunato Rocca

18. Mother's Name (First, Middle, Maiden Surname)

Frances Frallicciardi

19a. Informant's Name/Relationship (Type, Print)

Mrs. Frances Rocca (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8721 Valleyfield Road Lutherville, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

5/17/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Michael E. Canapp

22. Name and Address of Facility

LEONARD J. RUCK, INC.

5305 Harford Road

Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Endometrial Cancer

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☒ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Celano, M.D.

29c. License number

D30929

29d. Date signed (Month, Day, Year)

5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Celano, MD 6509 N. Charles St., BALTIMORE, MD 21204

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

Jenna B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16126

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN E. MULLENEX				2. Date of Death Month Day Year MAY 17, 1999				3. Time of Death 10:39 A.M.	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death	
Funeral Director	5. Social Security Number 196.12.1064		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) 2/20/1924		9. Birthplace (State or Foreign Country) PENNSYLVANIA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County ANNE ARUNDEL		10c. City, Town or Location PASADENA				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 200 DELEWARE AVENUE				10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRANSPORTATION				16b. Kind of Business/Industry SCM CORPORATION			
	17. Father's Name (First, Middle, Last) CHARLES W. MACFARLAND				18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE WEEKLEY					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CAROLE HOWELL - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 DELAWARE AVENUE, PASADENA, MD 21122					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Date 5/18		20d. Location - City or Town, State BALTIMORE, MD			
	21. Signature of Funeral Service Licensed KELLY GREGORY FINK				22. Name and Address of Facility FINK FUNERAL HOME, P.A. 426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>brain herniation</u></p> <p>Due to (or as a consequence of):</p> <p>b. <u>brain tumor</u></p> <p>Due to (or as a consequence of):</p> <p>c.</p> <p>Due to (or as a consequence of):</p> <p>d.</p> <p>Approximate Interval Between Onset and Death</p> <p>36 hours</p> <p>5 days</p>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Leo</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <u>Munt...</u>				29c. License number P11515			29d. Date signed (Month, Day, Year) MAY 17, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. MEHTA 22 South Greene St. Baltimore, Md 21201										
31. Date filed (Month, Day, Year) MAY 18 1999		32. Registrar's Signature <u>Bernard B. Sparks</u>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item 20b per FH,G771,05/19/99dhb

Certificate of Death

Reg. No.

3. Time of Death  
5:45 P

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)  
ISABEL

B.

MALOFF

2. Date of Death  
Month Day Year  
May 12 1999

Funeral  
Director

4a. Facility Name (If not institution, give street and number)  
LEVINDALE NURSING HOME

4b. City, Town, or Location of Death  
BALTIMORE

4c. County of Death  
N/A

5. Social Security Number  
213-05-4422

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
90 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth (Month, Day, Year)  
NOV. 13, 1908

9. Birthplace (State or Foreign Country)  
MD

Usual Residence of Decedent

10a. State  
MD

10b. County  
CARROLL

10c. City, Town or Location  
SYKESVILLE

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number  
603 TANGLEWOOD DRIVE

10f. Zip Code  
21784

10g. Citizen of What Country?  
U.S.A.

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 12  
College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
HOUSEWIFE

16b. Kind of Business/Industry  
OWN HOME

17. Father's Name (First, Middle, Last)  
MORRIS

BLOOM

18. Mother's Name (First, Middle, Maiden Surname)  
LENA

ACHBORG

19a. Informant's Name/Relationship (Type, Print)  
MARSHA MALOFF / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
603 TANGLEWOOD DRIVE - SYKESVILLE, MD 21784

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
OHEL YAKOV - BETH ISRAEL  
YAKOV

Date  
5/14/99

20c. Location - City or Town, State  
BALTIMORE, MD

21. Signature of Funeral Service Licensee

*Jan Allen*

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Hypernatremia*

Due to (or as a consequence of):

48 hours

*Dehydration*

Due to (or as a consequence of):

48 hours

*Parkinson's Disease*

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Debra S Wertheimer*

29c. License number

D23767

29d. Date signed (Month, Day, Year)

May 12, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DEBRA S WERTHEIMER MD 2434 W. Belvedere Ave, Balto, MD 21215

31. Date filed (Month, Day, Year)  
MAY 19 1999

32. Registrar's Signature

*Debra S. Wertheimer*

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16128

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Irvin Nickles				2. Date of Death Month Day Year MAY 15, 1999		3. Time of Death 2:00 P.M.	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-24-1184		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F X	7. Age (in yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/3/1928	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 4126 Glen Park Drive				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Mechanic		16b. Kind of Business/Industry Automobile			
	17. Father's Name (First, Middle, Last) Arthur Irvin Nickles				18. Mother's Name (First, Middle, Maiden Surname) Barbara G. Langer			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lawrence A. Nickles				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5128 Henry Avenue Baltimore, Maryland 21236			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Date 5/19/99		20d. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee Monty Dippel				22. Name and Address of Facility Dippel Funeral home Inc. 7110 Belair road Baltimore, Maryland 21206			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 YEARS			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier W. Agathe		29c. License number RD # 189142		29d. Date signed (Month, Day, Year) MAY 15, 1999	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WELEN AGATHE MD 9000 FRANKLIN SQUARE DR. BALTO, MD 21237							
	31. Date filed (Month, Day, Year) MAY 18 1999				32. Registrar's Signature G. Sparks			

NICKLES, CHARLES

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16129

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mabel Pizarro				2. Date of Death Month Day Year May 15, 1999				3. Time of Death 3:30 AM	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Perring Parkway Center				4b. City, Town, or Location of Death Parkville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-32-3576		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) March 20, 1932		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 418 Calvin Avenue				10f. Zip Code 21218		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson				16b. Kind of Business/Industry Retail Clothing	
	17. Father's Name (First, Middle, Last) William Lewis				18. Mother's Name (First, Middle, Maiden Surname) Mabel North					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Suzanne D. Magaha Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3206 Chestnut Avenue, Baltimore, Maryland 21211					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory Baltimore-Washington		20c. Date 5/21/99		20d. Location - City or Town, State Laurel, Maryland			
	21. Signature of Funeral Service Licensee Lynn B. Henss				22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastasis of Breast Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier Attending Physician				29c. License number D0053642				29d. Date signed (Month, Day, Year) May 17 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XIAOMING ZHOU 3007 E Northern Parkway Baltimore MD									
	31. Date filed (Month, Day, Year) May 19 1999				32. Registrar's Signature S. Sparks					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16130

DOROTHY PRICE May 18, 1999 1:00 p.m.


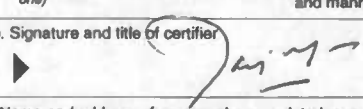

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY BEATRICE PRICE</b>				2. Date of Death Month Day Year <b>May 18 1999</b>		3. Time of Death <b>1:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>				4b. City, Town, or Location of Death <b>TIMONIUM</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>220 05 0310</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 25, 1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1709 Evergreen Dr.</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Quality Control Clerk</b>			16b. Kind of Business/Industry <b>Steel Mill</b>	
17. Father's Name (First, Middle, Last) <b>(Unknown) Hewes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Hooven</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sandra Frank / Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2137 Scottwood Ave., Toledo, OH 43620</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		Date <b>5/19/99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. LUNG CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>5/18/99</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>								
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>				32. Registrar's Signature 				

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY VIRGINIA PITTS

2. Date of Death

MAY 14, 1999

3. Time of Death

0547

4a. Facility Name (If not institution, give street and number)

1440 GORDON DRIVE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

217.20.6329

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

10/21/1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

1440 GORDON DRIVE

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOOKKEEPER

16b. Kind of Business/Industry

WESTINGHOUSE

17. Father's Name (First, Middle, Last)

C. RAYMOND EARHARDT

18. Mother's Name (First, Middle, Maiden Surname)

EMMA DANNENFELSOR

19a. Informant's Name/Relationship (Type, Print)

BARBARA LEE PITTS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1440 GORDON DRIVE, GLEN BURNIE, MD 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY

Date

5/15

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, P.A.  
426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG TUMOR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Gregory Fink

29c. License number

D37111

29d. Date signed (Month, Day, Year)

5/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

606 HAMMONDS LN BALTIMORE, MD 21225

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT M RYAN, SR</b>		2. Date of Death Month <b>MAY</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>13:00</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTRE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>213-30-7926</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>June 18, 1932</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10e. Street and Number <b>568 Chalcot Square</b>			10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>12/4/52</b> <b>12/3/54</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electronics Technician</b>		16b. Kind of Business/Industry <b>Equipment Manufacture</b>			
17. Father's Name (First, Middle, Last) <b>Robert Lee Ryan</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Laura Meskill</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Evelyn Ryan (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>568 Chalcot Square, Baltimore, Maryland 21221</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>John W. Buckowski</b>		22. Name and Address of Facility <b>Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b>  Due to (or as a consequence of): <b>PERFORATED APPENDIX</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>≥ 4 weeks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HTN, NIDDM, CVA</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Are MD</b>		29c. License number <b>P10902</b>	29d. Date signed (Month, Day, Year) <b>MAY 16, 1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C - ARE, Johns Hopkins Bayview Medical Center</b>					
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <b>Barbara B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16133

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIOLA E. RILEY</b>						2. Date of Death Month <b>MAY</b> Day <b>12</b> Year <b>1999</b>		3. Time of Death <b>2:47 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-12-5192</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 11, 1924</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>1422 Medfield Avenue</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Walter J. Ridgeley</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mattie Parks</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Sherman E. Riley Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1422 Medfield Avenue, Baltimore, Maryland 21211</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		Date <b>5/15/99</b>		20c. Location - City or Town, State <b>Fullerton, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Byron B. Henss</b>				22. Name and Address of Facility <b>Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland</b>					
	23a. Part I. Under the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPTIC SHOCK</b> Due to (or as a consequence of): <b>b. ARDS, ACUTE RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of): <b>c. PNEUMONIA</b> Due to (or as a consequence of): <b>d.</b>									
	Approximate Interval Between Onset and Death <b>4 DAYS</b> <b>4 DAYS</b> <b>7 DAYS</b>									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>Donal SETHI, MD</b>				29c. License number <b>AT2438946</b>		29d. Date signed (Month, Day, Year) <b>MAY 19, 1999</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DONAL SETHI, UNION MEMORIAL HOSPITAL 201 EAST UNIVERSITY PARKWAY BALTIMORE 21239</b>									
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <b>Donal S. Sparks</b>								

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16134

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frank B. Russo				2. Date of Death Month Day Year May 18, 1999				3. Time of Death 5:00 AM			
	4a. Facility Name (If not institution, give street and number) 4300 Sweet Air Road				4b. City, Town, or Location of Death Baldwin				4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 218-14-0320		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) 1-9-1908		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baldwin				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 4300 Sweet Air Road				10f. Zip Code 21013		10g. Citizen of What Country? U. S. A.					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Antique Business				16b. Kind of Business/Industry Sunnybrook Blacksmith			
	17. Father's Name (First, Middle, Last) Frank Russo, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Edythe Kirkley							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs Jacquelyn Russo (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Sweet Air Road, Baldwin, Maryland 21013							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Long Green Cem.		20c. Location - City or Town, State Hydes, Maryland		20d. Date 5-21-99					
	21. Signature of Funeral Service Licensee Wallace S. Brooks Jr.				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md. 21204				1050 York Road			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC PROSTATE CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death MONTHS	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. CONGESTIVE HEART FAILURE										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier James G. Ebeling, M.D.				29c. License number D34827		29d. Date signed (Month, Day, Year) 5/18/99			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) James G. Ebeling, M.D. 7401 Osler Drive Towson, Md. 21204											
	31. Date filed (Month, Day, Year) MAY 19 1999				32. Registrar's Signature Benita B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

4410



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

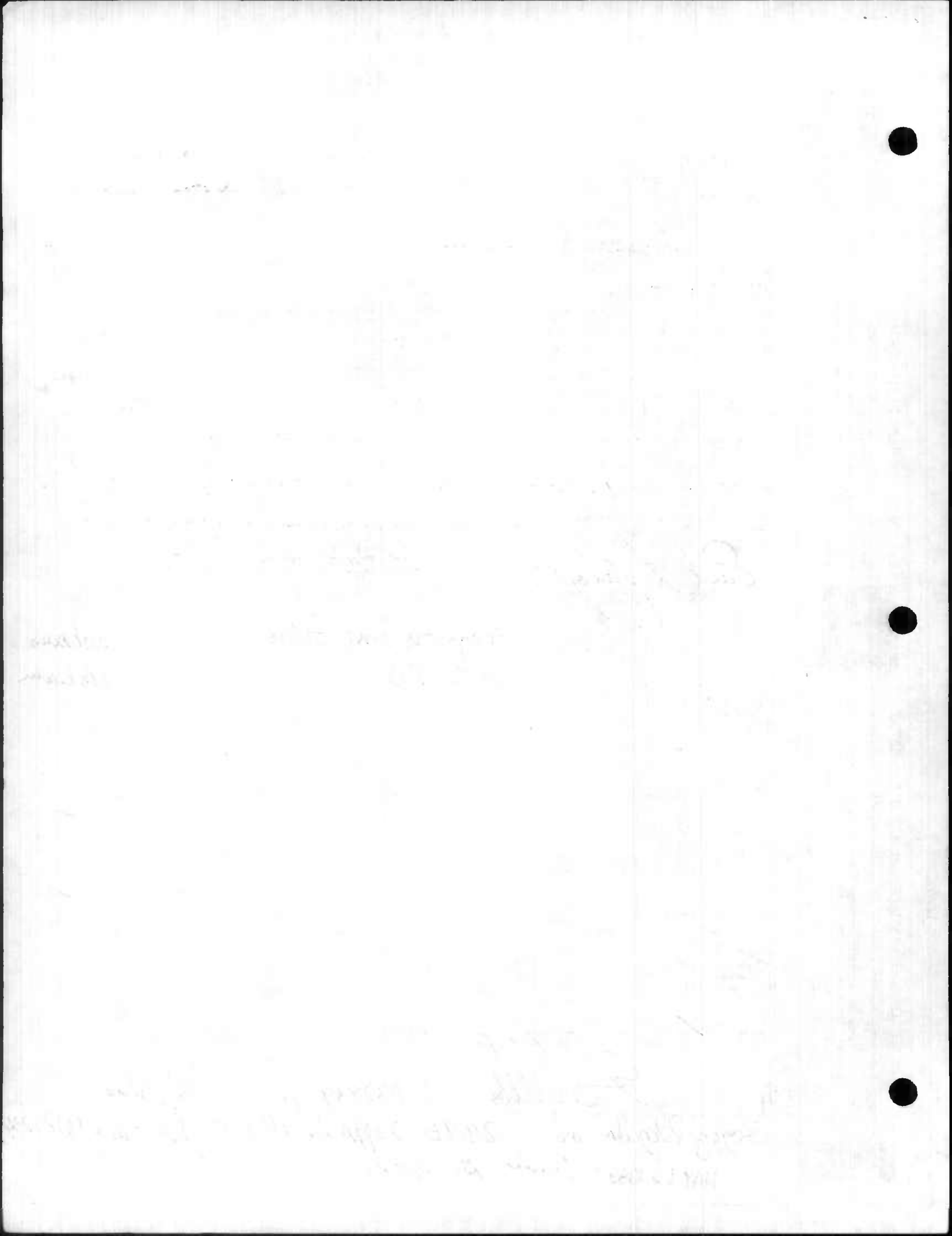
99 16135

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia J. Rainey					2. Date of Death Month Day Year May 15 1999		3. Time of Death 6:40AM			
	4a. Facility Name (If not institution, give street and number) Genesis Loch Raven					4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 212-30-4869		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 16 1915		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 8115 Glen Gary Rd.					10f. Zip Code 21234		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Callistus Leo Hickey					18. Mother's Name (First, Middle, Maiden Surname) Rose Marie Weber						
19a. Informant's Name/Relationship (Type, Print) Ms. Colleen Nelson/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Ballycruy Ct. #201 Timonium, MD. 21093						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cemetery 5-18-99			20c. Location - City or Town, State Baltimore, MD.					
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204						
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death unknown unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 					29c. License number D32939		29d. Date signed (Month, Day, Year) 5/17/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory Pokryshko MD 2914 E. Joppa Rd #103, Baltimore, MD 21234											
31. Date filed (Month, Day, Year) MAY 19 1999			32. Registrar's Signature 								

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ALFONZO

State of Maryland / Department of Health and Mental Hygiene

ROGERS

ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-1-99

Certificate of Death

Reg. No.

99 16136

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alfonzo Rogers</b>				2. Date of Death Month: <b>MAY</b> Day: <b>15</b> Year: <b>1999</b>		3. Time of Death <b>8:53 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>3502 ROUND ROAD</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>263-57-6442</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>39</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 10, 1959</b>		9. Birthplace (State or Foreign Country) <b>South Carolina</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>1034 Bethune Rd.</b>			10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Afro-American</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12</b> College (1-4 or 5+): <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Construction</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Willie Rogers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Deare Gamble</b>				
	19a. Informant's Name/Relationship (Type, Print) (sister) <b>Ms. Patricia Rogers</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2356 Norfolk St. Balto. Md. 21230</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		20c. Location - City or Town, State <b>5/22/99 Lansdowne, Md.</b>		20d. Date		
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death):</b> <b>NARCOTIC INTOXICATION</b> Due to (or as a consequence of): <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:</b> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>						
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5-15-99</b>		28b. Time of Injury <b>8:46</b> P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>David R. Fowler</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 16, 1999</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <b>Benita B. Sparks</b>						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16137

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph A. Rolek</b>				2. Date of Death Month Day Year <b>May 16 1999</b>		3. Time of Death <b>10:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>22 Winona Ave</b>				4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>232-26-1335</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan 13 1920</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number <b>22 Winona Ave</b>				10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electronics Technician</b>			16b. Kind of Business/Industry <b>Defense Contractor</b>	
17. Father's Name (First, Middle, Last) <b>Ludwig Rolek</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Kokaszka</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marie Rolek /wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 Winona Ave Baltimore, MD 21222</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>May 20 1999</b>		20c. Location - City or Town, State <b>Catonsville, MD</b>	
21. Signature of Funeral Service Licensee <b>Anthony C. Connelly</b>				22. Name and Address of Facility <b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Total Arrhythmia</b> Due to (or as a consequence of): <b>b. Congestive Heart Failure</b> Due to (or as a consequence of): <b>c. myocardial Ischemia</b> Due to (or as a consequence of): <b>d. Atherosclerotic Heart Disease</b>								Approximate Interval Between Onset and Death <b>4 min</b> <b>2 yrs</b> <b>10 yrs</b> <b>20 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Lung Cancer</b> <b>Renal Insufficiency</b>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>William Dando MD</b>		29c. License number <b>050835</b>		29d. Date signed (Month, Day, Year) <b>5-16-1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Dando MD 1576 merriett Blvd Baltimore MD</b>								
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>				32. Registrar's Signature <b>[Signature]</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16138

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH

ROSEMAN

2. Date of Death

MAY 15, 1999

3. Time of Death

3:14 PM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

215-48-6497

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

DEC. 10, 1903

9. Birthplace (State or Foreign Country)

LITHUANIA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1801 JEFFERSON STREET #T10

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN-

19a. Informant's Name/Relationship (Type, Print)

BYRON ROSEMAN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4491 SEPULVEDA BLVD. - CULVER CITY, CA 90230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MIKRO KODESH BETH ISRAEL

Date

5/17/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Asystole*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Myocardial Infarction*  
Due to (or as a consequence of):c. *Coronary Artery Disease*  
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E.N. Bodurcian 5536 Wisc. Ave #515 Chevy Chase Md 20815

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

5-15-99 3:14 PM Sarah Roseman



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16139

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

John Spruill

2. Date of Death

Month

Day

Year

May 16 1999

3. Time of Death

11:20 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

245-01-1405

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept. 18, 1917

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1562 Elrino Street

10f. Zip Code

21224

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

None

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Merchant Seaman

16b. Kind of Business/Industry

Seaman

17. Father's Name (First, Middle, Last)

Arthur J. Spruill

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Massiner

19a. Informant's Name/Relationship (Type, Print)

Mrs. Annie Spruill/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1562 Elrino Street Baltimore, Maryland 21224

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Loudon Park Cemetery 5/19/1999

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Johnny Y. Ellis

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Gastrointestinal bleed

Due to (or as a consequence of):

2 months

b. Duodenal ulcer

Due to (or as a consequence of):

2 months

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol abuse

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy  
performed?

1 Yes 2 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 Yes 2 No

25. Was case referred to medical  
examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending  
2 Accident investigation  
3 Suicide 6 Could not be  
4 Homicide determined

28e. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David Yu, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

May 16, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

David Yu, MD, Tower 110, Johns Hopkins Hospital, Baltimore, Maryland 21205

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GERTRUDE

2. Date of Death

Month

Day

Year

MAY 13 1999

3. Time of Death

8:50 AM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDERCARE - RANDALLSTOWN

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

218-10-9978

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct 31, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9109 LIBERTY RD.

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

FEDERAL COURT

17. Father's Name (First, Middle, Last)

MATTHEW

SWERDLOFF

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER

HECKER

19a. Informant's Name/Relationship (Type, Print)

NeeTu DHAWAN-GRAY, STATE GUARDIAN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 CATHEDRAL ST. BALTIMORE, MD 21201

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON (CHIZUK AMUNO)

Date

5/14/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Scott M. Little

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gastric carcinoma

Approximate Interval Between Onset and Death

18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Breast Carcinoma

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jerome H. Ginsberg

29c. License number

D0020964

29d. Date signed (Month, Day, Year)

5-13-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

Jerome H. Ginsberg

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

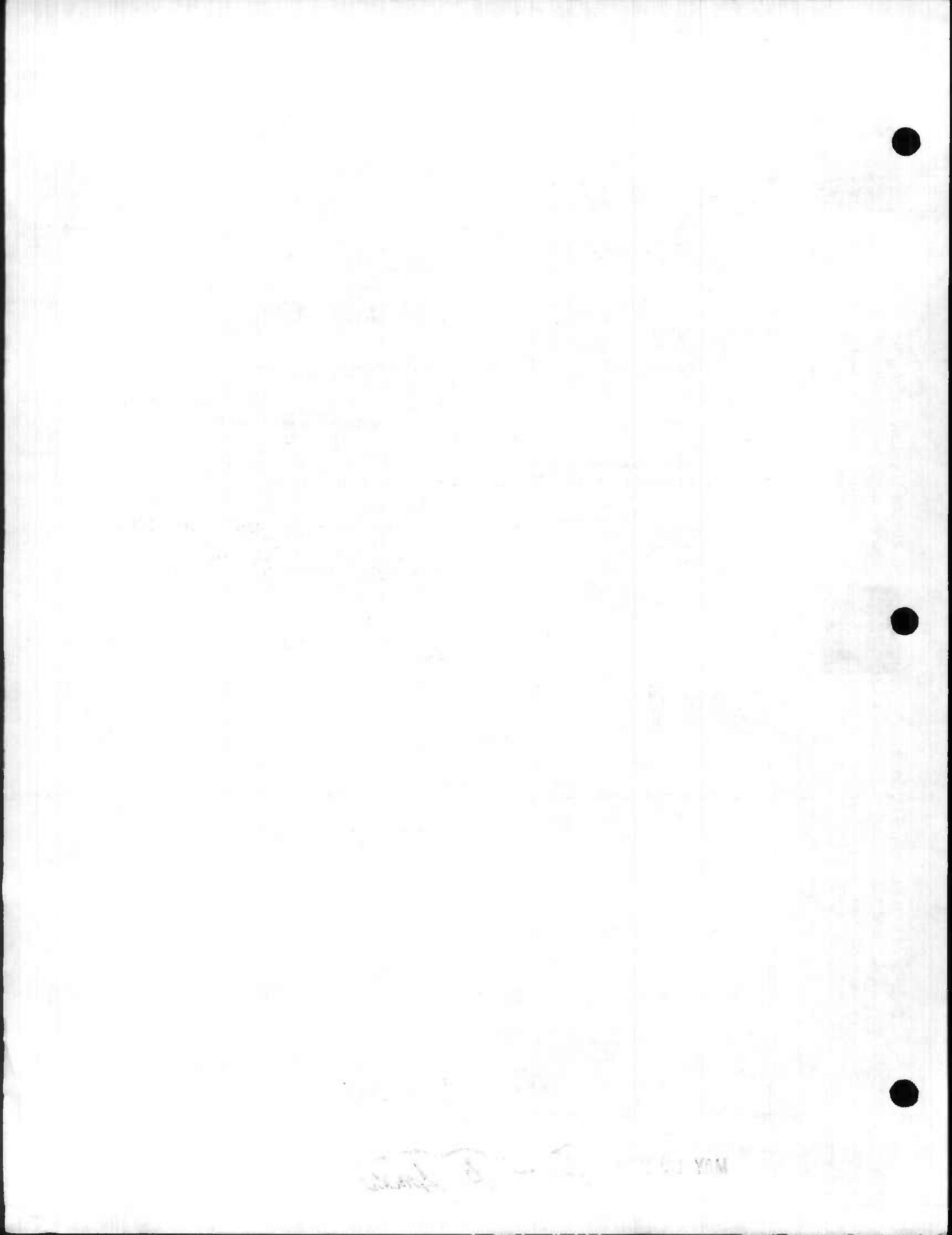
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Sent B - 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

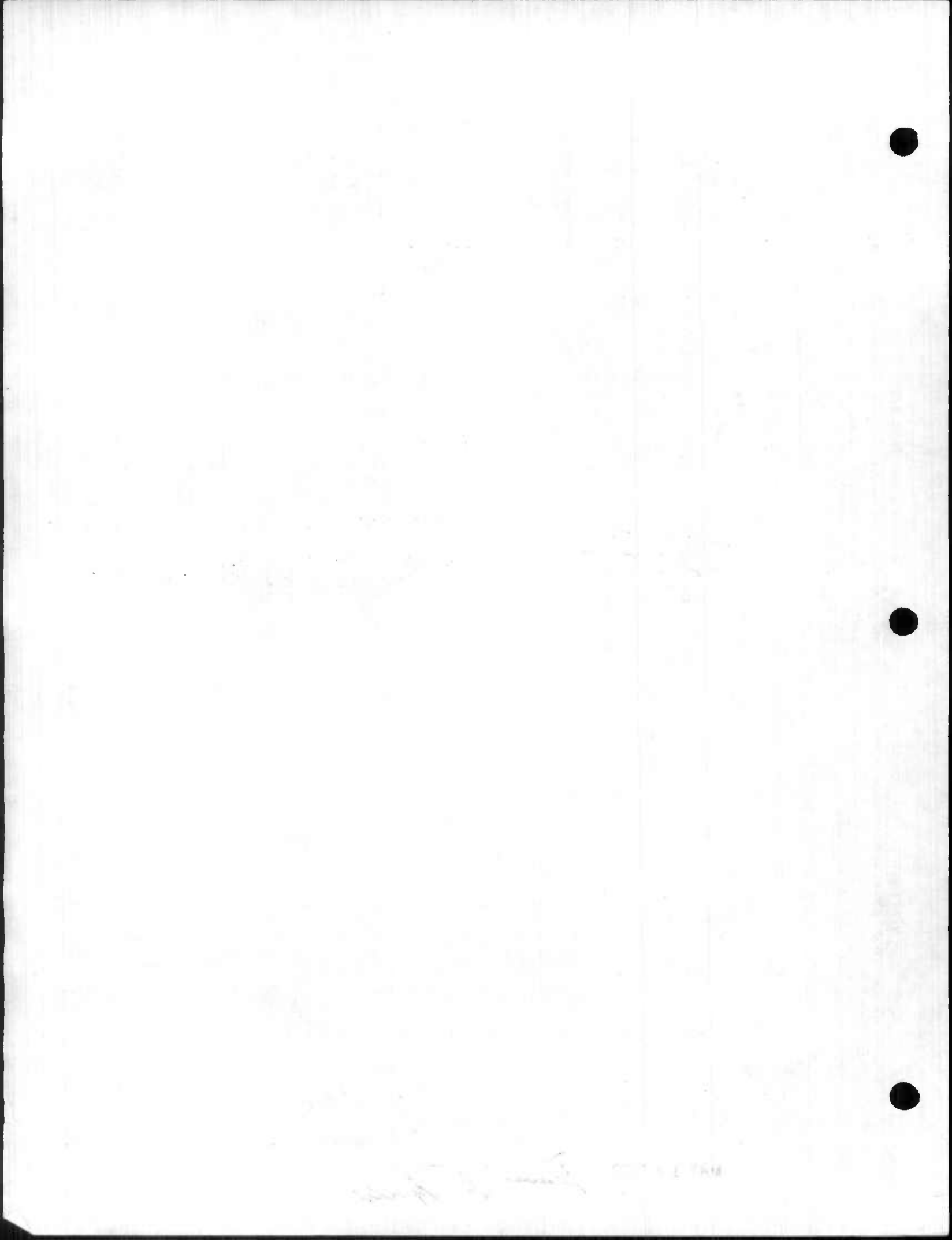
Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>SAMUEL STAIMAN</b>		2. Date of Death Month <b>MAY</b> Day <b>15</b> Year <b>1999</b>		3. Time of Death <b>7:20 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>NORTH OAKS</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
5. Social Security Number <b>213-05-6850</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>97</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>JUNE 16, 1901</b>	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>725 MT. WILSON LANE</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country?
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COLLECTOR</b>		16b. Kind of Business/Industry <b>CREDIT BUREAU OF BALTO</b>
17. Father's Name (First, Middle, Last) <b>LOUIS STAIMAN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA COHEN</b>		
19a. Informant's Name/Relationship (Type, Print) <b>MORTON MILLER NEPHEW</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4400 SILVERBROOK LANE #F103 OWINGS MILLS MD 21117</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>AGUDAS BNAI JACOB LODGE</b>		20c. Location - City or Town, State <b>ROSEDALE, MD</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Lung Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Insufficiency</b> <b>Edema</b> <b>Pleural Effusions</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>053283</b>	
29d. Data signed (Month, Day, Year) <b>5/15/99</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Christopher Ish MD 1147 South Hanover St Baltimore MD 21230</b>					
31. Data filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16142

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Esther Mae Scheller

2. Date of Death

May 18 1999

3. Time of Death

7:30 AM

4a. Facility Name (If not institution, give street and number)

304 E. Belvedere Ave.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-32-8297

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
November 21, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

304 E. Belvedere Ave.

10f. Zip Code

21212

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

electrical/appliance

17. Father's Name (First, Middle, Last)

William Potee Moon, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Marion Louise Roberts

19a. Informant's Name/Relationship (Type, Print)

George Scheller/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

304 E. Belvedere Ave. Baltimore, MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parkwood Cemetery

Date

5/21/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John O. Mitchell IV

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.

6500 York Rd.

Baltimore, MD 21212

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Breast Carcinoma  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

15 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Charles Padgett MD

29c. License number

DIS576

29d. Date signed (Month, Day, Year)

May 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Padgett MD, 5601 Loch Raven Blvd., Baltimore, MD 21239

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

J. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
3035.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16143

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DANIEL SILESKY</b>				2. Date of Death Month Day Year <b>MAY 14 1999</b>		3. Time of Death <b>8:00AM</b>									
	4a. Facility Name (If not institution, give street and number) <b>2500 W. BELVEDERE AVE., APT. 609</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>									
Funeral Director	5. Social Security Number <b>215-12-7079</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>SEPT 29, 1900</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>									
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
	10e. Street and Number <b>2500 W. BELVEDERE AVE., APT. 609</b>			10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CIVIL ENGINEER</b>		16b. Kind of Business/Industry <b>BALTIMORE CITY</b>											
	17. Father's Name (First, Middle, Last) <b>MAX SILESKY</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA SAVAGE</b>												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>MRS. MINA GOODMAN (DAUG.)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5748 CROSS COUNTRY BLVD. BALTO., MD 21209</b>												
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON (CHIZUK AMUNO)</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>											
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208</b>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>cardiac arrest</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>1 hr</b>   <b>1 mo</b>   <b>Yr</b> </td> </tr> <tr> <td>b.</td> <td><b>1TP - Idiopathic thrombocytopenic purpura</b></td> </tr> <tr> <td>c.</td> <td><b>coronary artery disease</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>cardiac arrest</b>	Approximate Interval Between Onset and Death  <b>1 hr</b>  <b>1 mo</b>  <b>Yr</b>	b.	<b>1TP - Idiopathic thrombocytopenic purpura</b>	c.	<b>coronary artery disease</b>	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>cardiac arrest</b>	Approximate Interval Between Onset and Death  <b>1 hr</b>  <b>1 mo</b>  <b>Yr</b>													
	b.	<b>1TP - Idiopathic thrombocytopenic purpura</b>														
	c.	<b>coronary artery disease</b>														
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>none</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred												
28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier <b>Alan Kimmel MD</b>				29c. License number <b>D25783</b>		29d. Date signed (Month, Day, Year) <b>5-14-99</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alan Kimmel MD 220 W. Cold Spring Lane Balt MD 21210</b>																
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

John A. Smith



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

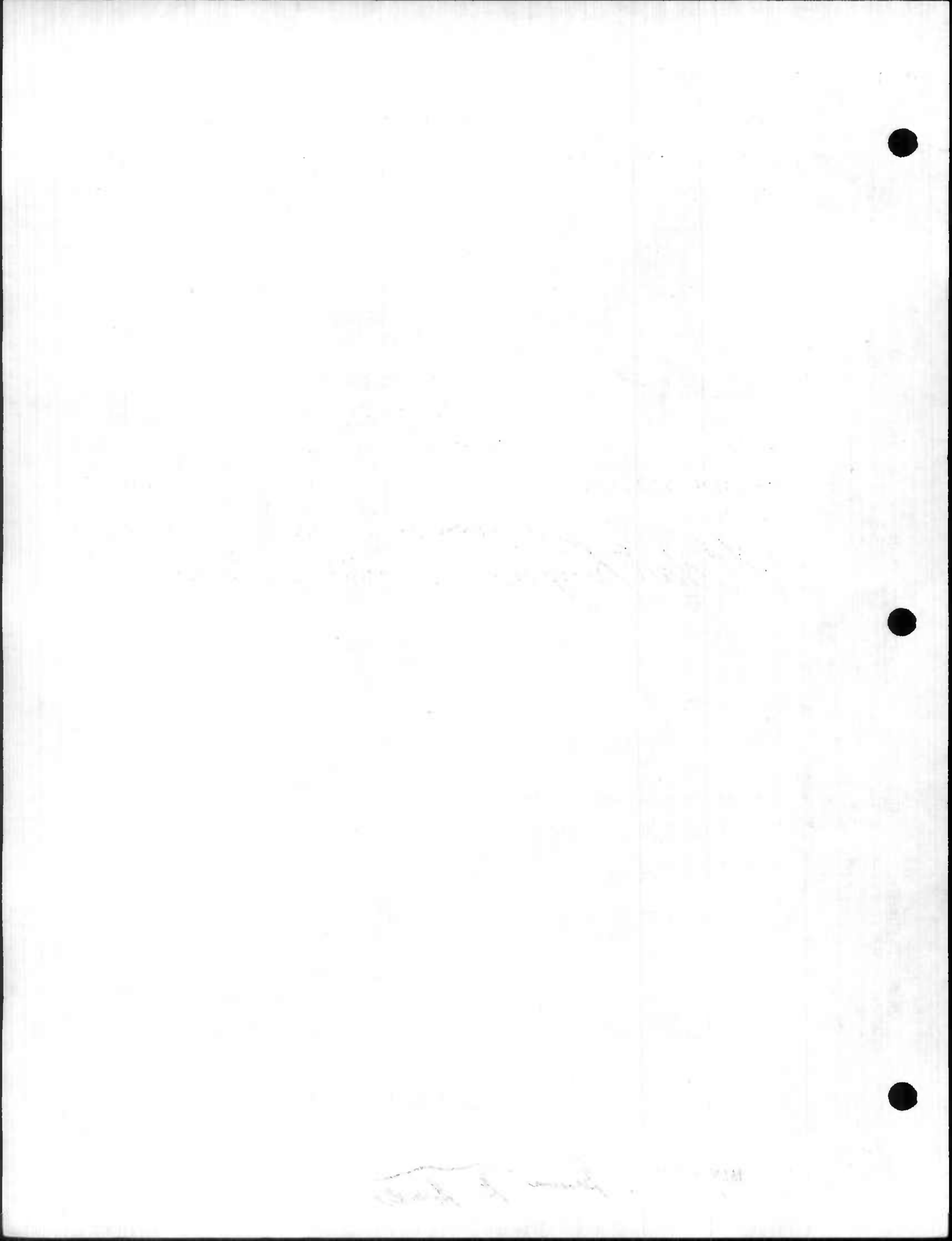
99 16144

Amended Item 6 per FH,6771,5/19/99dhb

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BERKO SUKHARCHUK				2. Date of Death Month Day Year MAY 14 1999		3. Time of Death 3:30PM		
	4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 122-66-7988		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86	8. Date of Birth (Month, Day, Year) DEC 13, 1912		9. Birthplace (State or Foreign) UKRAINE		
	Usual Residence of Decedent								
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 3615 FORDS LA., APT. 710				10f. Zip Code 21215		10g. Citizen of What Country? UKRAINE			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARBER		16b. Kind of Business/Industry COSMETOLOGY			
17. Father's Name (First, Middle, Last) MOSHE SUKHARCHUK				18. Mother's Name (First, Middle, Maiden Surname) BAYLA					
19a. Informant's Name/Relationship (Type, Print) MRS. LUNA SHPIRT (DAUG.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8007-D GREENSPRING WAY OWINGS MILLS, MD 21117					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		Date 5/16/99		20c. Location - City or Town, State REISTERSTOWN, MD			
21. Signature of Funeral Service Licensed				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC PANCREATIC CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 1 YEAR	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier L J Mathew		29c. License number 050164		29d. Date signed (Month, Day, Year) 5/15/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L J Mathew, Jewish Convalescent Home									
31. Date filed (Month, Day, Year) MAY 19 1999		32. Registrar's Signature B. Spates							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Turner

2. Date of Death

May 17, 1999

3. Time of Death

6:05a.m.

4a. Facility Name (If not institution, give street and number)

Villa St. Michaels

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

219-58-2003

6. Sex

M 20 F

7. Age (In yrs. last birthday)

43

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 15, 1955

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Vare Hills

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1406 Gardman Avenue

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Limousine Owner

16b. Kind of Business/Industry

Limousine Service

17. Father's Name (First, Middle, Last)

Milton M. Turner

18. Mother's Name (First, Middle, Maiden Surname)

Mary Spriggs

19a. Informant's Name/Relationship (Type, Print)

Mary Turner

mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1406 Gardman Avenue Vare Hills, Md. 21209

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

May 19

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Herbert E. Nutter

22. Name and Address of Facility

Nutter Funeral Homes, Inc.

2501 Gwynns Falls PKWY Baltimore, Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. End Stage Acquired Immune deficiency Syndrome  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension; Hypo Seizures  
Malnutrition; Cachexia

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician

2 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Salvo

29c. License number

D17537

29d. Date signed (Month, Day, Year)

5-18-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAN S. SALUJAND 1600 W. MOUNT Royal Ave, Baltimore MD 21217

31. Date filed (Month, Day, Year)

MAY 19 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

8:45 pm

Storch, Gloria 5/16/99

Division of Vital Records, P.O. Box 68760,

5

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Gloria Barbara Storch</b>		2. Date of Death Month <b>May</b> Day <b>16</b> Year <b>1999</b>		3. Time of Death <b>8:45pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Gilcrest Center for Hospice</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>212-30-9847</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b>	
8. Date of Birth Month <b>4</b> Day <b>16</b> Year <b>32</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Nottingham</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>9639 Hickory Hurst Dr.</b>		10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Legal Secretary</b>		16b. Kind of Business/Industry <b>Law</b>	
17. Father's Name (First, Middle, Last) <b>Andrew Panuska</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mamie Kuderna</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Martin Storch/husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9639 Hickory Hurst Dr. Baltimore, MD 21236</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Memorial</b>		20c. Location - City or Town, State <b>5-20-99 Middle River, MD</b>	
21. Signature of Funeral Service Licensee <i>Dennis S. Kelly</i>		22. Name and Address of Facility <b>Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Breast Cancer</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death <b>years</b>	
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dr. Anthony Riley, MD</i>		29c. License number <b>D25205</b>	
29d. Date signed (Month, Day, Year) <b>May 17, 1999</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W. A. Riley GIB NC 6201 W. Charles St. Balto. md 21208</b>					
31. Date filed (Month, Day, Year) <b>MAY 18 1999</b>		32. Registrar's Signature <i>G. Sparks</i>			

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99-16147

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elmer D. Wilkins</b>				2. Date of Death Month <b>May</b> Day <b>15</b> Year <b>1999</b>		3. Time of Death <b>09:07PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>VA Maryland Health Care System</b>				4b. City, Town, or Location of Death <b>Perry Point</b>		4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>216-36-6676</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 2, 1939</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>
To Be Completed by Funeral Director		10e. Street and Number <b>2550 Druid Hill Ave.</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>			
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Afro-American</b>	
To Be Completed by Physician/Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>			
		17. Father's Name (First, Middle, Last) <b>Daniel Wilkins</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Woods</b>					
To Be Completed by Physician/Medical Examiner		19a. Informant's Name/Relationship (Type, Print) (sister) <b>Mrs. Audrey Greene</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2550 Druid Hill Ave. Balto. Md. 21217</b>					
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		20c. Location - City or Town, State <b>5/20/99 Owings Mills, Md.</b>		20d. Date	
To Be Completed by Physician/Medical Examiner		21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>					
		23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung cancer</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>Unknown</b>					
To Be Completed by Physician/Medical Examiner		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
		29b. Signature and title of certifier <b>John Mulligan</b>		29c. License number <b>22100-DC</b>		29d. Date signed (Month, Day, Year) <b>May 15, 1999</b>			
To Be Completed by Physician/Medical Examiner		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOHN MULLIGAN, M.D., VA Maryland Health Care System, Perry Point, MD 21902</b>							
		31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>		32. Registrar's Signature <b>Phenwa B. Sparks</b>					

NAME KNOWN TO PHYSICIAN: ELMER D. WILKINS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16148

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Herbert Williams</b>				2. Date of Death Month <b>May</b> Day <b>13</b> Year <b>1999</b>				3. Time of Death <b>7 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>CATON MANOR GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>				4c. County of Death <b>—</b>	
Funeral Director	5. Social Security Number <b>228-18-5089</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth Month <b>07</b> Day <b>19</b> Year <b>1921</b>		9. Birthplace (State or Foreign Country) <b>Va</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>421 E. Federal St.</b>				10f. Zip Code <b>21202</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>				16b. Kind of Business/Industry <b>Steel</b>		
17. Father's Name (First, Middle, Last) <b>Eugene Williams</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maggie Thomas</b>						
19a. Informant's Name/Relationship (Type, Print) <b>George Williams</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3210 Westmont Ave. Balto, MD. 21216</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>mt. Zion Cemetery</b>		Date <b>5/19/99</b>		20c. Location - City or Town, State <b>Lansdowne, MD.</b>				
21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Gary P. March Funeral Home P.A. 240 Fredrickson Pass, Balto., MD. 21229</b>						
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute Cerebrovascular Accident</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Alzheimer's Disease</b> <b>Parkinson's disease</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				Approximate Interval Between Onset and Death <b>1 Day</b>		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>William M. Attending Doctor</b>				29c. License number <b>D 21684</b>		
29d. Date signed (Month, Day, Year) <b>5-14-99</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C.V. CYRIAC - 7-D FLORES RITCHIE HWY, PASADENA, MD 21122</b>										
31. Date filed (Month, Day, Year) <b>MAY 19 1999</b>				32. Registrar's Signature <b>[Signature] B. Sparks</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1. The first part of the paper is devoted to a general discussion of the problem.

2. In the second part, we consider the case of a single particle.

3. The third part is devoted to the case of a system of particles.

4. In the fourth part, we consider the case of a continuous medium.

5. The fifth part is devoted to the case of a discrete system.

6. The sixth part is devoted to the case of a continuous system.

7. The seventh part is devoted to the case of a discrete system.

8. The eighth part is devoted to the case of a continuous system.

9. The ninth part is devoted to the case of a discrete system.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT LEO WILT

2. Date of Death

MAY 14, 1999

3. Time of Death

3:25 P.M.

4a. Facility Name (If not institution, give street and number)

HARBOR IN CONVALESCENT CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

231.22.7625

6. Sex

XXM 2□F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MAY 17, 1927

9. Birthplace (State or Foreign Country)

WVA

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

XX Yes 2□ No

10e. Street and Number

1213 LIGHT STREET

10f. Zip Code

21230

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1□ Never Married 2□ Married  
3□ Widowed 4XX Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1XX Yes 2□ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

WELDER

16b. Kind of Business/Industry

BOILERMAKERS UNION

17. Father's Name (First, Middle, Last)

KENNETH LEON WILT

18. Mother's Name (First, Middle, Maiden Surname)

IDA MAE KINSLEY

19a. Informant's Name/Relationship (Type, Print)

BILLY GENE WILT

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17 BON AIR AVENUE, BALTIMORE, MD 21225

20a. Method of Disposition

1□ Burial 2XX Cremation 3□ Removal from State  
4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEM. PK.

Date

5/19

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

KELLY GREGORY FINK

22. Name and Address of Facility

FINK FUNERAL HOME, P.A.

426 CRAIN HWY., S.W., GLEN BURNIE, MD 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Larynx and Pharynx 6 month

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3XX Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2XX No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2XX No

25. Was case referred to medical examiner?

1□ Yes 2XX No

26. Place of Death (Check only one)

Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4XX Nursing Home 5□ Residence 6□ Other (Specify)

27. Manner of Death

1XX Natural 5□ Pending Investigation  
2□ Accident 6□ Could not be determined  
3□ Suicide  
4□ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Assem a. Haseem MD.

29c. License number

D15503

29d. Date signed (Month, Day, Year)

5/18/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOROTHY H. NAREEM, 501 DOLPHIN ST Balto MD 21217

31. Date filed (Month, Day, Year)

MAY 18 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



WRC  
99-2186-510  
MATT  
WATT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16150

ITEMS: #23 PART I, 27, 28A-F PER MEO G771 5-20-99 WR. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Matt Watt				2. Date of Death Month Day Year APRIL 14, 1999				3. Time of Death 10:55 PM.						
	4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death						
Funeral Director	5. Social Security Number unknown		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) unknown Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) unknown		9. Birthplace (State or Foreign Country) unknown		
	Usual Residence of Decedent														
10a. State Maryland		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
10e. Street and Number 404 S. Patterson Park Ave.				10f. Zip Code 21231				10g. Citizen of What Country? unknown							
11. Marital Status unknown 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? unknown 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: unknown				14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown				College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				16b. Kind of Business/Industry unknown			
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Summa) unknown											
19a. Informant's Name/Relationship (Type, Print) unknown				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) Data				20c. Location - City or Town, State							
21. Signature of Funeral Service Licensee  Ronald S. Wade				22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201											
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) MULTIPLE INJURIES Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) Found: 4-14-99		28b. Time of Injury Found: 10:55		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred JUMPED FROM WINDOW					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: OUTSIDE RESIDENCE				28f. Location (Street and Number or Rural Route Number, City or Town, State) 404 S. PATTERSON PK. AVE BALTIMORE, MARYLAND											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) APRIL 15, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  P. W. W. W. 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) MAY 18 1999				32. Registrar's Signature  B. Sparks											





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16151

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellen N. Abbott

2. Date of Death

MAY 5, 1999

3. Time of Death

16:40

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

218-01-3116

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jun 9, 1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

Queen City Towers--Paca Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

State Inspector

16b. Kind of Business/Industry

Bd of Cosmetology

17. Father's Name (First, Middle, Last)

Stanley Alexander

18. Mother's Name (First, Middle, Maiden Surname)

Emma (nmn)

19a. Informant's Name/Relationship (Type, Print)

Edward T. Abbott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

313 Cole Street; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Memorial Gard 5/07/ LaVale, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name of Funeral Home

Scarpelli's Funeral Home P.A.

Cumberland, Maryland 21502

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. POSTOBSTRUCTIVE PNEUMONIA

Due to (or as a consequence of):

6 weeks

b. NON SMALL CELL LUNG CANCER

Due to (or as a consequence of):

1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D18769

29d. Date signed (Month, Day, Year)

May 6 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES RAVEN, M.D., MEMORIAL HOSPITAL SUITE 400 CUMBERLAND MD 21502

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

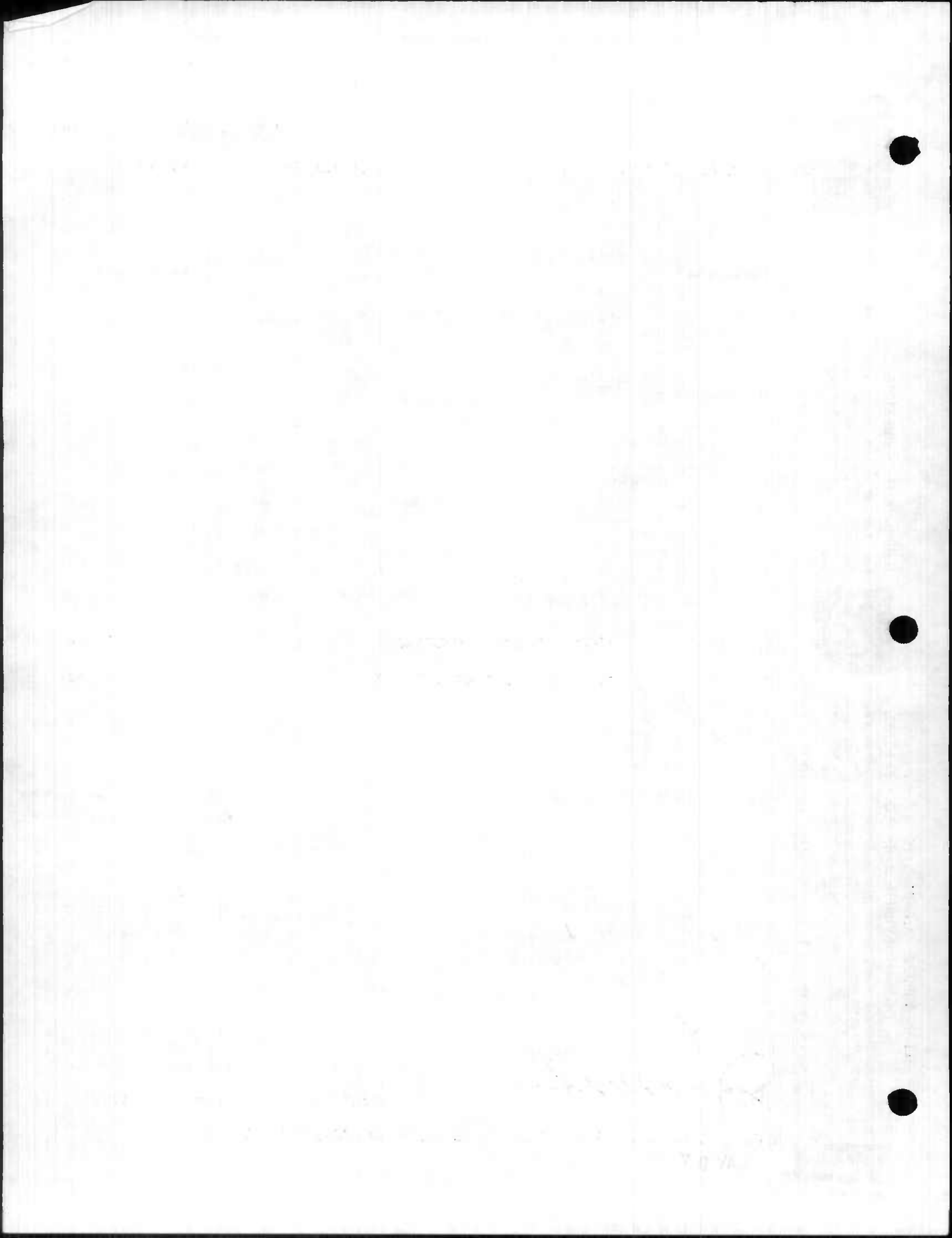
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ELLEN ABBOTT 218-01-3116

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16152

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth Victor Bosley</b>				2. Date of Death Month Day Year <b>April 29, 1999</b>				3. Time of Death <b>10:40 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4651 George Washington Highway</b>				4b. City, Town, or Location of Death <b>Oakland</b>				4c. County of Death <b>Garrett</b>	
Funeral Director	5. Social Security Number <b>217-20-8132</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 16, 1925</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>4651 George Washington Highway</b>				10f. Zip Code <b>21550</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>43-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed</b>				16b. Kind of Business/Industry <b>Service Station</b>		
17. Father's Name (First, Middle, Last) <b>Evers Orloff Bosley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Estella Otelia Dilgard</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Juanita L. Bosley/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4651 George Washinton Hwy., Oakland, Md. 21550</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pope Cemetery</b>		Date <b>5/2/99</b>		20c. Location - City or Town, State <b>Gorman, Maryland</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stewart Funeral Home</b> <b>32 S. Second St., Oakland, Md. 21550</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Prostatic Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>2 years</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b> <b>Coronary Artery Disease</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number <b>H26154</b>		29d. Date signed (Month, Day, Year) <b>5/1/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul D. Miller, MD 69 wolf Acres Dr., Oakland, Md. 21550</b>										
31. Date filed (Month, Day, Year) <b>MAY - 3 1999</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1511VA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 16153

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES ELLEN VIRGINIA BITTNER				2. Date of Death Month Day Year MAY 8, 1999		3. Time of Death 1925
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL			4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 212 24 1055	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) MAY 3 1915	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ALLEGANY	10c. City, Town or Location FROSTBURG		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 51 MILL STREET		10f. Zip Code 21532		10g. Citizen of What Country? U.S.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) WILLIAM F. TWIGG			18. Mother's Name (First, Middle, Maiden Surname) EDITH BRINKMAN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) DONNA JEAN BITTNER / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 BRADDOCK HEIGHTS, FROSTBURG, MD 21532				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FROSTBURG MEMORIAL PARK 5/11/99		20c. Location - City or Town, State FROSTBURG, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION 12 HOURS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE CHRONIC OBSTRUCTIVE PULMONARY DIS.						
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 		29c. License number D24951		29d. Date signed (Month, Day, Year) MAY 8, 1999		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chang Oh M.D. 48 Tarn Terrace Frostburg, MD 21532.						
31. Date filed (Month, Day, Year) MAY 11 1999		32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16154

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN ERVIN BLANK

2. Date of Death

Month

Day

Year

May

10

1999

3. Time of Death

12:30 AM

4a. Facility Name (If not institution, give street and number)

10923 GREEN ROW ROAD, NW,

4b. City, Town, or Location of Death

FROSTBURG

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

214 07 2671

6. Sex

☒ M☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

SEPT 9 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10923 GREEN ROW ROAD, NW

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER/OPERATOR

16b. Kind of Business/Industry

TAVERN

17. Father's Name (First, Middle, Last)

CHARLES E. BLANK

18. Mother's Name (First, Middle, Maiden Surname)

MARY BELLE (STEVENS)

19a. Informant's Name/Relationship (Type, Print)

HAZEL E. BLANK / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10923 GREEN ROW ROAD, NW, FROSTBURG, MD 21532

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ROCKY GAP VETERANS CEM

Date

5/12/99

20c. Location - City or Town, State

FLINTSTONE, MD

21. Signature of Funeral Service Licensee

Alan M Sowers

22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.

60 W. MAIN ST., FROSTBURG, MD 21532

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 minute

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

emphysema

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation☐ Accident ☐ Could not be determined☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Donald E. Manger DME MD

29c. License number

DU 5231

29d. Date signed (Month, Day, Year)

May 10 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD E. MANGER 11427 HAZEL RD 21502

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit notice.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16155

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Marie Bartik</b>				2. Date of Death Month Day Year <b>May 5, 1999</b>		3. Time of Death <b>8:43 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>219-20-1548</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1924</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>McCoole (Westernport)</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>21609 McCoole Drive, S.W.</b>				10f. Zip Code <b>21562</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Alvin Russell Llewellyn</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Essie Marie Baker</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Shirley A. Bartik/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21609 McCoole Drive, S.W. Westernport, MD 21562</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Potomac Memorial Gardens</b>		Date <b>May 9 1999</b>		20c. Location - City or Town, State <b>Keyser, WV</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 26726</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac arrest - Congestive HF Failure</b> Due to (or as a consequence of): <b>b. Renal Failure</b> Due to (or as a consequence of): <b>c. Multiple system organ failure</b> Due to (or as a consequence of): <b>d. Sepsis from leg osteomyelitis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pt refusal of leg amputation</b>								Approximate Interval Between Onset and Death	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner				29b. Signature and Title of Certifier 				29c. License number <b>D34653</b>	
29d. Date signed (Month, Day, Year) <b>May 7 1999</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. William Palin, Johnson Heights Medical Bldg., Cumberland, MD 21502</b>									
31. Date filed (Month, Day, Year) <b>MAY 10 1999</b>									
Registrar's Signature 									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16156

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Juanita Bean</b>				2. Date of Death Month Day Year <b>May 4, 1999</b>				3. Time of Death <b>5:12 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>215-18-8755</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 3, 1923</b>		9. Birthplace (State or Foreign Country) <b>WV</b>	
	Usual Residence of Decedent				10a. State <b>WV</b>		10b. County <b>Mineral</b>		10c. City, Town or Location <b>Keyser</b>	
10e. Street and Number <b>Rt. 4 Box 508</b>		10f. Zip Code <b>26726</b>		10g. Citizen of What Country? <b>United States</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>						
17. Father's Name (First, Middle, Last) <b>George Duckworth</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Janet Metz</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Arthur Bean, Jr./ Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt 4 Box 508 Keyser, WV 26726</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Potomac Memorial Gardens</b>		20c. Location - City or Town, State <b>Keyser, WV 26726</b>		20d. Date <b>5/6/99</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Boal Funeral Home Westernport, MD 21562</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. POORLY DIFFERENTIATED CARCINOMA (NEUROENDOCRINE)</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>FEBRUARY '97</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>D 23371</b>		29d. Date signed (Month, Day, Year) <b>May 4 1999</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dr. Q. Zaman, Johnson Heights Medical Bldg., Cumberland, MD 21502</b>				31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

JUANITA BEAN 215-18-8755

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

99 16157

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY EVELYN BUSCH

2. Date of Death

Month MAY 5 Day 1999 Year

3. Time of Death

11:37 AM

4a. Facility Name (If not institution, give street and number)

7 RIDGEWAY TERRACE

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

216-18-1401

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JULY 4 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7 RIDGEWAY TERRACE

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

RETAIL CLERK IN STORE

16b. Kind of Business/Industry

WALLPAPER STORE

17. Father's Name (First, Middle, Last)

CHARLES ANDREW SHIPE

18. Mother's Name (First, Middle, Maiden Surname)

ADA GORMER

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA L. HUDSON

DAUGHTER 240 MASSACHUSETTS AVE. CUMBERLAND MARYLAND 21502

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

SUNSET CEMETERY MAY 10 1999

Date

20c. Location - City or Town, State

CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

Emphysema

Approximate  
Interval Between  
Onset and Death

10 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis with severe hypoxemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony J. Bollino, Jr.

29c. License number

D 17565

29d. Date signed (Month, Day, Year)

MAY 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. ANTHONY J. BOLLINO, JR. 922 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

31. Date filed (Month, Day, Year)

MAY 6 7 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Handwritten signature or initials, possibly "H. M. L." or similar, in the center of the page.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16158

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard Lee Carter</b>				2. Date of Death Month Day Year <b>May 9 1999</b>		3. Time of Death <b>2:25PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>213-82-7691</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>42</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>15-Mar-57</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>Martin's Lane</b>		10f. Zip Code <b>21532-</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>cook</b>		16b. Kind of Business/Industry <b>restaurant</b>					
17. Father's Name (First, Middle, Last) <b>Harold Richard Carter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pauline Barrett</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rev. George M. Harp Cousin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 444 Frostburg Maryland 21532-</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Eckhart Cemetery</b>		Date <b>11-May-99</b>		20c. Location - City or Town, State <b>Eckhart, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiac arrhythmia</b> Due to (or as a consequence of): <b>Hypertensive cardiovascular heart disease</b>		Approximate Interval Between Onset and Death <b>1 1/2 hrs</b> <b>uk yrs</b>		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Obesity</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)		27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>Dpty Med Ex</b>		29c. License number <b>D 09157</b>		29d. Date signed (Month, Day, Year) <b>May 9 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Snow, M.D. 124 w 3rd st Cumberland Md 21502</b>		31. Date filed (Month, Day, Year) <b>MAY 10 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5  
160

213-82-7891

42

12-Mar-27

Maryland

Maryland

Allegany

Frostburg

Martin's Lane

21232-

U.S.A.

White

12

0

restaurant

Harold Richard Carter

Pauline Barnett

Rev. George M. Harp Cousin

P.O. Box 444

Frostburg

Maryland 21232-

Eckhart Cemetery

11-May-98 Eckhart, Maryland

Dust Funeral Home, 27 First Ave., Frostburg, MD 21232

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16159

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Virginia D. Collins

2. Date of Death

MAY

Day

2 1999

Year

3. Time of Death

11:25 AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

233-38-4920

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 18, 1917

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Hampshire

10c. City, Town or Location

Romney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

HC 63, Box 2580

10f. Zip Code

26757

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

teacher

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

Harry E. Duckworth

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Haines

19a. Informant's Name/Relationship (Type, Print)

Elizabeth D. Wolford, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

485 Everett Place, Romney, WV 26757

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Ceme. 5/11/99

Date

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

Shaffer Funeral Home, Inc.

22. Name and Address of Facility

230 E. Main St., Romney, WV 26757

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Gastrointestinal bleeding

Due to (or as a consequence of):

Possible peptic ulcer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerosis

Emphysema

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George Breza MD

29c. License number

D12532

29d. Date signed (Month, Day, Year)

MAY 3 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Breza M.D. 912 Seton Drive Cumberland MD 21502

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-638-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

ms

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16160

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Geraldine Elizabeth Duling</b>				2. Date of Death Month Day Year <b>APRIL 24, 1999</b>				3. Time of Death <b>1540</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>232-26-3844</b>		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) <b>Aug. 8, 1920</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		Usual Residence of Decedent		10a. State <b>WV</b>		10b. County <b>Hampshire</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Romney</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>HC 65 P.O. Box 890</b>		10f. Zip Code <b>26757</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>House Keeping</b>		16b. Kind of Business/Industry <b>Domestic</b>		17. Father's Name (First, Middle, Last) <b>Gamer McDonald, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Stella Dawson McDonald</b>		19a. Informant's Name/Relationship (Type, Print) <b>Judy Clower-Nazelrod</b>	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HC 63 Box 780, Romney, WV 26757</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Ebenezer Cemetery</b>		20c. Date <b>04/27/99</b>		20d. Location - City or Town, State <b>Romney, WV</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>D. Page Baldwin</b> WV Funeral Director #1320 WV Embalmers #1620		22. Name and Address of Facility <b>Baldwin Funeral Home, Inc.</b> <b>P.O. Box 1940, Romney, WV 26757</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b> Due to (or as a consequence of): <b>Bacterial pneumonia</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of):    Approximate Interval Between Onset and Death <b>16 days</b> <b>16 days</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
To Be Completed by Physician/Medical Examiner	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>S. V. Bellary M.D.</b>		29c. License number <b>D47507</b>		29d. Date signed (Month, Day, Year) <b>APRIL 26, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Somashekhar Bellary, M.D. - 224 Washington Street Cumberland MD 21022</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 11 1999</b>		32. Registrar's Signature <b>[Signature]</b>		33. Date of Death (Month, Day, Year) <b>APRIL 24, 1999</b>		34. Time of Death <b>1540</b>		35. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

St. Albans, Vermont

St. Albans, Vermont

335-28-0844

18

WV

Hampton

HC 85 P.O. Box 850

28157

United States

White

Domestic

House-keeping

12

Gamer, McDonald, Sr.

Stella Dawson McDonald

Judy Clower-Nelson

HC 83 Box 180, Romney, WV 26757

General Cemetery

048792 Romney, WV

WV Funeral Director 81200  
WV Entomologist 81201

Baldwin Funeral Home, Inc.  
P.O. Box 1240 Romney, WV 26757

Community

Aug 8 1990

West Virginia



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16161

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD JOHN DAVIS

2. Date of Death

May 6, 1999

3. Time of Death

1815

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

219-40-2997

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 23, 1942

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

RAWLINGS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

LLEWELLYN AVENUE

10f. Zip Code

21557

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

MACHINIST HELPER

16b. Kind of Business/Industry

CSX RAILROAD

17. Father's Name (First, Middle, Last)

GEORGE WALTER DAVIS

18. Mother's Name (First, Middle, Maiden Surname)

OLIVE DAVIS

19a. Informant's Name/Relationship (Type, Print)

SUSAN LEE DAVIS / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 254 - RAWLINGS, MD 21557

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

RESTLAWN MEMORIAL GARDENS

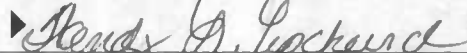
Date

5/10/99

20c. Location - City or Town, State

LAVALLE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST. CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Unbridled - fibrillation

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

b.

Cardiomyopathy

Due to (or as a consequence of):

3 years

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcoholism

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D35135

29d. Date signed (Month, Day, Year)

May 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas E. Chapman MD 912501 N Dr Cumberland MD

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

9





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16162

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEREW L. ENGLE				2. Date of Death Month Day Year May 3 1999				3. Time of Death 5:35a	
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton				4c. County of Death Talbot	
Funeral Director	5. Social Security Number 212-01-2033		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 20, 1914		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MD		10b. County CAROLINE		10c. City, Town or Location PRESTON				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 21340 DOVER BRIDGE ROAD				10f. Zip Code 21655				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER				16b. Kind of Business/Industry PRESTON TRUCKING		
17. Father's Name (First, Middle, Last) EDWARD V. LANE					18. Mother's Name (First, Middle, Maiden Surname) MARY WRIGHT					
19a. Informant's Name/Relationship (Type, Print) JOSEPH E. ENGLE / SON					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4282 POPLAR NECK ROAD, PRESTON, MD 21655					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) JR. ORDER CEMETERY		Date 5-6-99		20c. Location - City or Town, State PRESTON, MD			
21. Signature of Funeral Service Licensee JOHN R. MERCERON CFSP					22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Failure / Pneumonia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death ~10 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier C. Ruben m...				29c. License number D 52956		29d. Date signed (Month, Day, Year) 5/3/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA RUBIO, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601										
31. Date filed (Month, Day, Year) MAY 05 1999			32. Registrar's Signature B. Spauls							

ENGLE, LEREW

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 16163

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Frederick W. Warnick, Jr.</b>				2. Date of Death Month Day Year <b>April 27, 1999</b>		3. Time of Death <b>9:05 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>21602 Creek Side Drive, SW</b>				4b. City, Town, or Location of Death <b>Westernport</b>		4c. County of Death <b>Allegany</b>	
5. Social Security Number <b>220-82-0884</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>27</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 13, 1972</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Westernport</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10a. Street and Number <b>21602 Creek Side Drive, SW</b>				10f. Zip Code <b>21562</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teachers Assistant</b>		16b. Kind of Business/Industry <b>Allegany County Board of Education</b>	
17. Father's Name (First, Middle, Last) <b>Frederick W. Warnick, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Debra A. Trenum</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Frederick W. Warnick, Sr./Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HC 72 Box 89 M New Creek, WV 26743</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Philos Cemetery</b>		Date <b>4/30/99</b>		20c. Location - City or Town, State <b>Westernport, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>111 Church Street</b> <b>Boal Funeral Home Westernport, MD 21562</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Self inflicted gun shot wound to the chest sudden</b>  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Depressive disorder</b>  a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>4/27/99</b>		28b. Time of Injury <b>early AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how Injury occurred <b>Subject shot himself</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>residence</b>			
		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>21602 Creek Side Dr Franklin Md</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>Dpty Med</b>		29c. License number <b>Ex D09157</b>		29d. Date signed (Month, Day, Year) <b>April 27 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Snow, M.D. 124 W 3rd St Cumberland Md 21502</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be supported by proper documentation and that the records should be kept up-to-date at all times.

2. The second part of the document outlines the procedures for conducting regular audits. It states that audits should be performed at least once a year and that the results should be reported to the appropriate authorities. It also mentions that any discrepancies found during an audit should be investigated immediately.

3. The third part of the document describes the various methods used to collect and analyze data. It includes information about the different types of data that are collected, such as financial data, operational data, and customer data. It also discusses the various techniques used to analyze this data, such as statistical analysis and data mining.

4. The fourth part of the document discusses the importance of data security. It states that all data must be protected from unauthorized access and that appropriate security measures should be in place to ensure the confidentiality and integrity of the data. It also mentions that any breaches of data security should be reported immediately.

5. The fifth part of the document discusses the importance of data backup and recovery. It states that all data should be backed up regularly and that a plan should be in place to recover the data in the event of a disaster. It also mentions that the backup and recovery process should be tested regularly to ensure its effectiveness.

6. The sixth part of the document discusses the importance of data retention. It states that data should be retained for a specific period of time and that any data that is no longer needed should be securely deleted. It also mentions that the retention period should be determined based on the type of data and the applicable laws and regulations.

7. The seventh part of the document discusses the importance of data privacy. It states that all data must be handled in a way that respects the privacy of the individuals whose data it is. It also mentions that appropriate measures should be in place to ensure that the data is not shared with unauthorized parties.

8. The eighth part of the document discusses the importance of data governance. It states that there should be a clear policy and process for managing the data and that all employees should be trained on the data governance principles. It also mentions that the data governance process should be reviewed regularly to ensure its effectiveness.

9. The ninth part of the document discusses the importance of data quality. It states that all data should be accurate, complete, and consistent. It also mentions that appropriate measures should be in place to ensure the quality of the data, such as data validation and data cleansing.

10. The tenth part of the document discusses the importance of data integration. It states that data from different sources should be integrated in a way that allows for a comprehensive view of the organization's data. It also mentions that appropriate measures should be in place to ensure the integrity and consistency of the integrated data.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

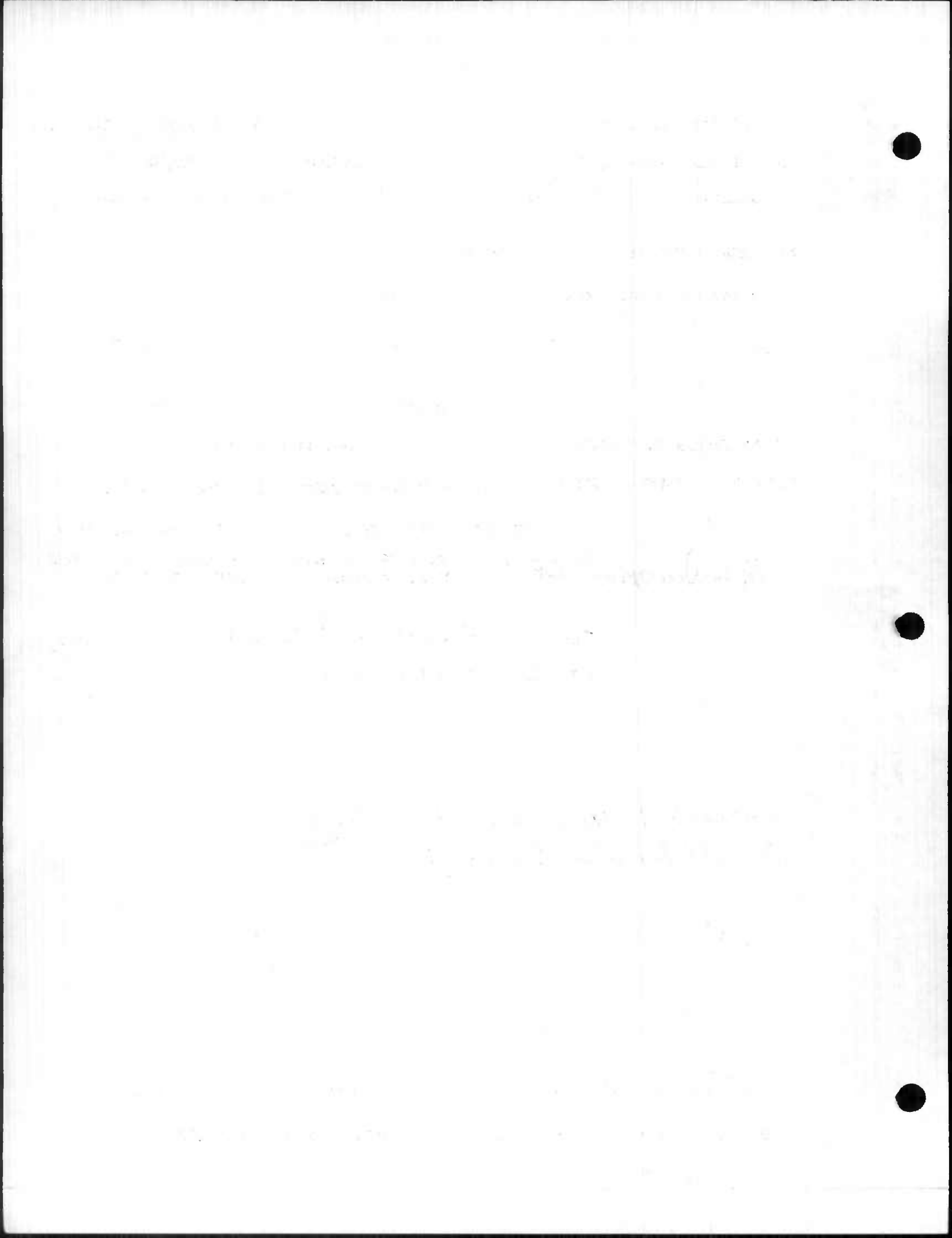
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16164

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES HECKERT FISHER</b>				2. Date of Death Month <b>APRIL</b> Day <b>30</b> , Year <b>1999</b>		3. Time of Death <b>2:20 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>27747 CEDAR POINT ROAD</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>219-46-4156</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV. 13, 1905</b>	
	9. Birthplace (State or Foreign Country) <b>PENNA.</b>		10a. State <b>MARYLAND</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>27747 CEDAR POINT ROAD</b>		10f. Zip Code <b>21601</b>	
	10g. Citizen of What Country? <b>U.S.</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>4</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>				16b. Kind of Business/Industry <b>OWN HOME</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>SIDNEY FREDERICK HECKERT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET MALONE</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>MARGARET F. TERRY/DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>108 ROCK SPRING COURT CARRBORO, N.C. 27510</b>			
To Be Completed by Physician/Medical Examiner	20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREM. CTR.</b>		20c. Location - City or Town, State <b>5-2-99 CHESTER, MD. 21619</b>	
	21. Signature of Funeral Service Licensee <i>M. E. Newman III C.F.S.P.</i>				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME 200 S. HARRISON ST. EASTON, MD. 21601</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Occlusion of Rt Middle Cerebral Artery</i> Due to (or as a consequence of): b. <i>Cerebral Infarction</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <i>2 days</i> <i>Sym</i>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic Heart Disease with Chronic Angiostenosis</i> <i>Chronic Obstructive Pulmonary Disease</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>William H. Wood, Jr. M.D.</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D08715</b>				29d. Date signed (Month, Day, Year) <b>4/30/99</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>WILLIAM H. WOOD, JR., M.D. 506 IDLEWILD AVE. EASTON, MD. 21601</b>				31. Date filed (Month, Day, Year) <b>MAY 02 1999</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>penne S. Sparks</i>				33. Registrar's Signature			
	34. Registrar's Signature				35. Registrar's Signature			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16165

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Francis Eugene Femi</b>				2. Date of Death Month Day Year <b>May 10 1999</b>		3. Time of Death <b>06:07 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>218-48-8899</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12-Sep-46</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Frostburg</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>109 Maple Terrace</b>		10f. Zip Code <b>21532</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>city water department</b>		17. Father's Name (First, Middle, Last) <b>Ernest Femi</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Wilma McKenzie</b>		19a. Informant's Name/Relationship (Type, Print) <b>Donna Femi Wife</b>	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>109 Maple Terrace Frostburg Maryland 21532</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Veteran's Cemetery - Rocky Gap</b>		20c. Location - City or Town, State <b>12-May-99 Cumberland, Maryland</b>		21. Signature of Funeral Service Licensee <i>John R. Durst</i>	
22. Name and Address of Facility <b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction</b>		Approximate Interval Between Onset and Death <b>30 min</b>		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
23d. Immediate Cause (Final disease or condition resulting in death) <b>Liver Cirrhosis</b>		Due to (or as a consequence of):		15 yrs		23e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		23f. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
23f. Subsequent Cause (Disease or injury that initiated events resulting in death) Last <b>Chronic Alcoholism</b>		Due to (or as a consequence of):		30 yrs		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Angela H. Roberts MD</i>		29c. License number <b>D 13166</b>	
29d. Date signed (Month, Day, Year) <b>May 10, 1999</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ANGEL H. ROBERTS MD, 48 TOWN TERRACE FROSTBURG, MD 21532</b>		31. Date filed (Month, Day, Year) <b>MAY 11 1999</b>		32. Registrar's Signature <i>[Signature]</i>		33. State Registrar	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

MA 1999 0607 AM

Allegany

Cumbeband

Maryland

15-26-44

25

Francis Eugene Femi

2000 Heart Hospital

218-48-8222

Maryland

Allegany

Frostburg

109 Maple Terrace

21233-

U.S.A.

White

12

0

Laborer

city water department

Wilma McKenzie

Guest Femi

Maryland 21233-

Frostburg

109 Maple Terrace

Wife

Donna Femi

Veteran Cemetery - Body 000 12-May-99 Cumbeband, Maryland

Dust Funeral Home, 57 First Ave., Frostburg, MD 21233

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16166

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathryn L. Franklin				2. Date of Death Month Day Year May 5, 1999				3. Time of Death 5:45 P.M.	
	4a. Facility Name (If not institution, give street and number) 607 Green Street				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany	
Funeral Director	5. Social Security Number 213-22-4051		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 10, 1909		9. Birthplace (State or Foreign Country) WV	
	Usual Residence of Decedent									
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 607 Green Street				10f. Zip Code 21502		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Celanese Corporation		
17. Father's Name (First, Middle, Last) Frank Brent Jones				18. Mother's Name (First, Middle, Maiden Surname) Catherine (Donnelly)						
19a. Informant's Name/Relationship (Type, Print) Bonnie Walter-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Green Street Cumberland MD 21502						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cumberland Crematory		20c. Location - City or Town, State 05/06 Cumberland MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. End Stage Senile Dementia Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Osteoporosis Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				Approximate Interval Between Onset and Death 2 years 40 years 30 years		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number 801951		
29d. Data signed (Month, Day, Year) 5/5/99				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. A. Leo Franklin 924 Seton Drive Cumberland MD 21502						
31. Date filed (Month, Day, Year) MAY 07 1999				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16167

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Donna V. Folk

2. Date of Death

Month  
May

Day

Year

4 1999

3. Time of Death

1230 AM

4a. Facility Name (If not institution, give street and number)

13 Bealls Lane

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegheny

5. Social Security Number

218-50-0489

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
13-Mar-31

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

Maryland

10b. County

Allegheny

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13 Bealls Lane

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9College (1-4 or 5+)  
016e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

health care provider

16b. Kind of Business/Industry

nursing home

17. Father's Name (First, Middle, Last)

Robert E. Grimes

18. Mother's Name (First, Middle, Maiden Surname)

Helen Donius

19a. Informant's Name/Relationship (Type, Print)

Carolyn Wolfe Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Bealls Lane Frostburg Maryland 21532-

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cumberland Crematory

Date

05-May-99

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Carcinoma Colon  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Angel Roque M.D.

29c. License number

D-13166

29d. Date signed (Month, Day, Year)

5/04/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angel Roque, M.D., Frostburg Community Medical Center, Frostburg, Maryland 21532

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2  
MSState  
Registrar

Durst Funeral Home, 57 First Ave., Frostburg, MD 21532

Cumberland Cemetery 05-May-99 Cumberland, Maryland

Carolyn Wolfe Daughter 13 Bealls Lane Frostburg Maryland 21532-

Robert E. Chines

Helen Donius

0

health care provider

nursing home

White

U.S.A.

21532-

13 Bealls Lane

Frostburg

Allegany

Maryland

218-20-0489

88

13-Mar-31

Pennsylvania

Frostburg

Allegany

MAY 4 1999 12:30 AM

Donna V. Folk



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS M. VANNUCCI

2. Date of Death

MAY

Day

1

Year

1999

3. Time of Death

3:30 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FROSTBURG VILLAGE NURSING HOME

4b. City, Town, or Location of Death

FROSTBURG

4c. County of Death

ALLEGANY

5. Social Security Number

175-14-6634

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 6, 1909

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

327 W. LIBERTY STREET

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PROPRIETOR

16b. Kind of Business/Industry

MOTEL

17. Father's Name (First, Middle, Last)

JOHN

BAINBRIDGE

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA

WILSON

19a. Informant's Name/Relationship (Type, Print)

KURT LEAR - GRANDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

803 HERITAGE DR. MT. LAKE PARK, MD 21550

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OMEGA CREMATORY

Data

5/4/99

20c. Location - City or Town, State

MORGANTOWN, WV

21. Signature of Funeral Service Licensee

MO0167

22. Name and Address of Facility

P.O. BOX 243

DURST FUNERAL HOME - OAKLAND, MD 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Respiratory failure

b.

Due to (or as a consequence of):

Emphysema

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

15 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D12532

29d. Date signed (Month, Day, Year)

MAY 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. GEORGE BREZA, 912 SETON DRIVE, CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

MAY - 5 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16169

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carl Elliott Growden</b>				2. Date of Death Month <b>MAY</b> Day <b>8</b> Year <b>1999</b>		3. Time of Death <b>12:45 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>215-20-7438</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 23, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>119 Mullen Street</b>		10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>retired repair tech</b>		16b. Kind of Business/Industry <b>Telephone Co.</b>			
	17. Father's Name (First, Middle, Last) <b>Charles Growden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret (Eichner)</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary Jo Growden wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>119 Mullen Street; Cumberland MD 21502</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		20c. Location - City or Town, State <b>5/11/ Cumberland, MD</b>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Michael J. Scarpelli</i>				22. Name and Address of Facility <b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Oat cell carcinoma of the lung</b> Due to (or as a consequence of): <b>b. Tobacco use</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Renal Failure</b> <b>Hypertension</b>				Approximate Interval Between Onset and Death <b>(4 weeks)</b> <b>4/14/99</b> <b>50 years</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b> <b>Hypertension</b>				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Dr. Albert Villarosa</i> m.p.				29c. License number <b>052056</b>		29d. Date signed (Month, Day, Year) <b>MAY 10, 1999</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Albert Villarosa 925 Bishop Walsh Road Cumberland MD 21502</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 11 1999</b>		32. Registrar's Signature <i>[Signature]</i>					

20 June  
(4 more)

On the ground in the mud

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16170

ITEM: # PER F.H G772 6-14-99 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN VIRGINIA GILLUM</b>				2. Date of Death Month Day Year <b>April 29, 1999</b>				3. Time of Death <b>6:00 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>@# 235-30-0259</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr 29, 1999</b>		9. Birthplace (State or Foreign Country) <b>WV</b>	
	Usual Residence of Decedent									
10a. State <b>WV</b>		10b. County <b>Mineral</b>		10c. City, Town or Location <b>Keyser</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>12 N. Main Street</b>				10f. Zip Code <b>26726</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Clerk</b>			16b. Kind of Business/Industry <b>D &amp; D Cleaners</b>			
17. Father's Name (First, Middle, Last) <b>nfn</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Glendora Daisy Perry</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Richard Gillum--grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 Homer Court; Virginia Beach, VA 23454</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Potomac Memorial Gardens</b>		Date <b>05/01</b>		20c. Location - City or Town, State <b>Keyser, WV</b>				
21. Signature of Funeral Service Licensee <i>Harold Dean Nofziger</i>				22. Name and Address of Facility <b>Markwood Funeral Home Keyser, WV 26726</b>						
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>VENTRICULAR ARRYTHMIAS</b> Due to (or as a consequence of):  b. <b>CARDIOMYOPATHY</b> Due to (or as a consequence of):  c. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death  <b>5 minutes</b>  <b>20 years</b>  <b>20 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE, HYPERTENSION</b>									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>N.A. Ranjithan</i>		29c. License number <b>D 19318</b>		29d. Date signed (Month, Day, Year) <b>April 3rd 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502</b>										
31. Date of Death (Month, Day, Year) <b>MAY 04 1999</b>										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

HELEN GILLUM 235-30-0259



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16171

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Lee HARSH

2. Date of Death

April 30, 1999

3. Time of Death

4:40 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

232-60-7402

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 8, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

WV

10b. County

Preston

10c. City, Town or Location

Aurora

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RR 1, Box 166

10f. Zip Code

26705

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietary Technician

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

James Lawrence Childs

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Martha Rinehart

19a. Informant's Name/Relationship (Type, Print)

Clyde A. Harsh/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RR 1, Box 166, Aurora, WV 26704

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Accident Cemetery

Date

5/3/99

20c. Location - City or Town, State

Horse Shoe Run, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, MD 21550

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

yrs

Due to (or as a consequence of):

b. Congestive heart disease (CHF)

yrs

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30035

29d. Date signed (Month, Day, Year)

04-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donald R. Richter M.D. 1533 Memorial Drive Oakland MD 21550

State  
Registrar

31. Date filed (Month, Day, Year)

MAY - 3 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 16172**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clara V. Haberlein

2. Date of Death

Month

Day

Year

May

10 1999

3. Time of Death

11:30 A.M.

4e. Facility Name (If not institution, give street and number)

Saint Vincent de Paul Nursing Center

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

220-28-9275

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

18-Dec-13

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

17205 Old National Pike, S.W.

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Johnny Broadwater

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Knox

19a. Informant's Name/Relationship (Type, Print)

Paul L. Haberlein Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17207 Old National Pike, S.W. Frostburg Maryland 21532-

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

13-May-99

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CVA  
Due to (or as a consequence of):

3 mos

c. HYPERTENSION  
Due to (or as a consequence of):

2 yrs.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

013166

29d. Date signed (Month, Day, Year)

5/10/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angel Roque, M.D., Frostburg Community Medical Center, Frostburg, Maryland 21532

31. Date filed (Month, Day, Year)

MAY 10 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

Quist Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Sunset Memorial Park 13-May-99 Cumberland, Maryland

Paul L. Habehrein Son 17205 Old National Pike, S.W. Frostburg Maryland 21532-

Johnny Broadwater

Isabelle Knox

Homemaker

Homemaker

White

21532-

U.S.A.

17205 Old National Pike, S.W.

Maryland Allegany Frostburg

220-28-9272 82

18-Dec-13

Maryland

Allegany

Frostburg

Saint Vincent de Paul Nursing Center

Clara V. Habehrein

May 10 1999 11:30 A.M.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16173

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>DALE M. HALLER</b>					2. Date of Death Month <b>MAY</b> Day <b>3</b> Year <b>1999</b>		3. Time of Death <b>1300</b>	
	4a. Facility Name (If not institution, give street and number) <b>511 MYRTH AVE</b>					4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
<b>Funeral Director</b>	5. Social Security Number <b>235-30-7329</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR 7, 1925</b>		9. Birthplace (State or Foreign Country) <b>WV</b>
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>511 Myrth Avenue</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired</b>			16b. Kind of Business/Industry <b>Glen L. Martin Co</b>		
17. Father's Name (First, Middle, Last) <b>Ray O. Haller</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Wilma (Murphy)</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Rachel A. Pingley</b> <b>sister</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 504; Elkins WV 26241</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Davis Memorial Cemetery</b>		Date <b>5/07/</b>		20c. Location - City or Town, State <b>Cumberland, MD</b>		
21. Signature of Funeral Service Licensee <i>Nicholas J. Scarpelli</i>					22. Name and Address of Family <b>Scarpelli Funeral Home P.A.</b> <b>Cumberland, Maryland 21502</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial infarction</b> Due to (or as a consequence of): <b>b. Chronic ischemic cardiovascular disease</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>10 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>J. Crossan O'Donovan, M.D.</b>					29c. License number <b>D07632</b>		29d. Date signed (Month, Day, Year) <b>MAY 3, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Crossan O'Donovan M.D., 2112 DUNDALK AVE., BALTO MD 21222</b>									
31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16174

Certificate of Death

Reg. No.

Irons, Ernest 1003

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ERNEST ANDREW IRONS</b>		2. Date of Death Month <b>MAY</b> Day <b>5</b> Year <b>1999</b>		3. Time of Death <b>6:19 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>FALLSTON GENERAL HOSPITAL</b>			4b. City, Town, or Location of Death <b>FALLSTON</b>		4c. County of Death <b>HARFORD</b>
5. Social Security Number <b>220-52-9578</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAR. 15, 1949</b>
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>ANNE ARUNDEL</b>	10c. City, Town or Location <b>FT. MEADE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1129-A LONG LOOP</b>			10f. Zip Code <b>20755</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOREMAN</b>		16b. Kind of Business/Industry <b>CONSTRUCTION</b>
17. Father's Name (First, Middle, Last) <b>JAMES N. IRONS</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>PEGGY ANN O'BAKER</b>		
19a. Informant's Name/Relationship (Type, Print) <b>PEGGY ANN IRONS / MOTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11502 BIERMAN DR., S.E., CUMBERLAND, MD 21502</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DAVIS MEMORIAL CEMETERY</b>		Date <b>5/8/99</b>	20c. Location - City or Town, State <b>CUMBERLAND, MD</b>
21. Signature of Funeral Service Licensee <i>Stoney D. Upchurch</i>			22. Name and Address of Facility <b>UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPTIC SHOCK</b> Due to (or as a consequence of): <b>b. Severe Infection.</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.					Approximate Interval Between Onset and Death <b>48 hrs</b> <b>5 days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End Stage Renal failure</b> <b>Severe Anemia</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)	28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Attending</i>		29c. License number <b>D.16444</b>		29d. Date signed (Month, Day, Year) <b>May 5 - 1999</b>	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>VIJAY. S. NAIR M.D. 2112 Belair Road. Fallston. MD 21047</b>					
31. Date filed (Month, Day, Year) <b>MAY 11 1999</b>		32. Registrar's Signature <i>[Signature]</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16175

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES LEE JOLLEY

2. Date of Death

Month  
MAY

Day

8,

Year

1999

3. Time of Death

09:22 AM

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

214-07-6855

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MAR. 2, 1910

9. Birthplace (State or Foreign

Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12212 McMULLEN HIGHWAY

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

FILTRATION WORKER

16b. Kind of Business/Industry

CELANESE CORPORATION

17. Father's Name (First, Middle, Last)

ELWOOD A. JOLLEY

18. Mother's Name (First, Middle, Maiden Surname)

IDA GORMER

19a. Informant's Name/Relationship (Type, Print)

MARY LEE KEGG / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

804 COLUMBIA AVENUE, CUMBERLAND, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HILLCREST BURIAL PARK

Date

5/11/99

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

▶ *Standy A. Upchurch*

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. hemorrhagic stroke

Due to (or as a consequence of):

b. bilateral subacute collection of fluid

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

3 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *Donald F. Munge*

29c. License number

D09231

29d. Date signed (Month, Day, Year)

MAY 8, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11600 Bedford Road N.E. CUMBERLAND MD

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature

▶ *[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16176

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Hughleen Kenner				2. Date of Death Month Day Year MAY 5 1999				3. Time of Death 8:54AM	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland				4c. County of Death Allegany	
Funeral Director	5. Social Security Number 215-36-9568		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) September 27 1937		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Midland				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 131 Paradise Street				10f. Zip Code 21542		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician			16b. Kind of Business/Industry Hair dressing			
	17. Father's Name (First, Middle, Last) Wilbur R. Crowe				18. Mother's Name (First, Middle, Maiden Surname) Mary P. McViegh					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Frances Skidmore daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19803 Big Lane, S.W., Midland, MD 21542					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Josephs Catholic		20c. Location - City or Town, State Midland, MD					
	21. Signature of Funeral Service Licensee James E McKenzie				22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. perforated viscous Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes chronic renal failure atrial fibrillation									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier Roy D. Chisholm, M.D.				29c. License number D34362		29d. Date signed (Month, Day, Year) MAY 5 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy D. Chisholm M.D. 924 Sebn Drive Cumberland MD 21502									
	31. Date filled (Month, Day, Year) MAY 07 1999				32. Registrar's Signature					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Robert Eugene Kuhn  
2. Date of Death Month May Day 2 Year 1999  
3. Time of Death 4:40AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 24712 Red Maple Road, S.W.  
4b. City, Town, or Location of Death Westernport  
4c. County of Death Allegany

5. Social Security Number 232-62-6438  
6. Sex 1 ☒ M 2 ☐ F  
7. Age (In yrs. last birthday) 58 Yrs.  
8. Date of Birth (Month, Day, Year) May 29, 1940  
9. Birthplace (State or Foreign Country) West Virginia

Usual Residence of Decedent

10a. State WV  
10b. County Mineral  
10c. City, Town or Location New Creek  
10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number General Delivery  
10f. Zip Code 26743  
10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Finishing Department 16b. Kind of Business/Industry Paper Mill

17. Father's Name (First, Middle, Last) James Bernard Kuhn  
18. Mother's Name (First, Middle, Maiden Surname) Sadie Price

19a. Informant's Name/Relationship (Type, Print) Robert E. Kuhn, II  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5041 US Highway 64 East Franklinville, NC 27248

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Memorial Gardens  
20c. Location - City or Town, State Keyser, WV  
Date 5/6/99

21. Signature of Funeral Service Licensee [Signature]  
22. Name and Address of Facility Rotruck-Smith Funeral Home  
85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic heart disease  
Due to (or as a consequence of): Uk yrs

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic aneurysm

COPD

23b. Did tobacco use contribute to the cause of death?  
1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No  
28. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined  
28a. Date of injury (Month, Day, Year)  
28b. Time of injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Piece of Injury - At home, term, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier [Signature] Dpty Med Ex  
29c. License number D 09157  
29d. Date signed (Month, Day, Year) May 2 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Paul Snow, M.D. 124 West Third St., Cumberland, MD 21502

31. Date filed (Month, Day, Year) MAY 04 1999  
32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

12

YKS

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16178

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Paul Lawhorne</b>				2. Date of Death Month <b>May</b> Day <b>5</b> Year <b>1999</b>		3. Time of Death <b>8:34 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>5868 Thompsonstown Rd.</b>				4b. City, Town, or Location of Death <b>East New Market</b>		4c. County of Death <b>Dorchester</b>	
Funeral Director	5. Social Security Number <b>210-34-1053</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 24, 1943</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Dorchester</b>		10c. City, Town or Location <b>East New Market</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>5868 Thompsonstown Road</b>				10f. Zip Code <b>21631</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>			16b. Kind of Business/Industry <b>State of Maryland</b>	
17. Father's Name (First, Middle, Last) <b>John Lawhorne</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Leathia Belton</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Kimberly Lawhorne, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5868 Thompsonstown Rd., East New Market, Md. 21631</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Capitol Crematory Chesterfield Cemetery</b>			20c. Location - City or Town, State <b>5/8/99 Dover, Delaware Centreville, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>a. Metastatic Rectal Carcinoma</b> Due to (or as a consequence of): <b>5 years</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</b> <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus, Arthritis</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Lois NARR D.O.</b>						
		29c. License number <b>H44615</b>		29d. Date signed (Month, Day, Year) <b>5/6/99</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lois NARR D.O. 2 Aurora St. Cambridge, Md. 21613</b>								
31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 16179

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Frances Louise McKeown				2. Date of Death Month Day Year May 06, 1999				3. Time of Death 8:58AM	
4a. Facility Name (If not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death La Plata				4c. County of Death Charles	
5. Social Security Number 579-24-4688		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 19, 1914		9. Birthplace (State or Foreign Country) Washington D.C.	
Usual Residence of Decedent									
10a. State Maryland		10b. County Charles		10c. City, Town or Location Nanjemoy				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 4020 Port Tobacco Road				10f. Zip Code 20662		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Her Home		
17. Father's Name (First, Middle, Last) Harry Good					18. Mother's Name (First, Middle, Maiden Surname) Carrie Lena Dowell				
19a. Informant's Name/Relationship (Type, Print) Linda M. Rothgeb/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6085 Hannon Drive, LaPlata, Maryland 20646					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Nanjemoy Baptist Church Cemetery		Date May 10, 1999		20c. Location - City or Town, State Nanjemoy, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland 20640					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <u>Cardiac Arrest</u> Due to (or as a consequence of): b. <u>Hypertensive Cardiovascular Disease</u> Due to (or as a consequence of): c. <u>Atrial Fibrillation</u> Due to (or as a consequence of): d. <u>Cor Pulmonale</u>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <u>Cardiac Arrest</u> Due to (or as a consequence of): b. <u>Hypertensive Cardiovascular Disease</u> Due to (or as a consequence of): c. <u>Atrial Fibrillation</u> Due to (or as a consequence of): d. <u>Cor Pulmonale</u>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypothyroidism</u> <u>Benign Tumor</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D-01009		29d. Date signed (Month, Day, Year) 5-6-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Henry L. Burke, MD 115-A LaGrange Avenue P.O. Box 2539 La Plata, Maryland 20646									
31. Date filed (Month, Day, Year) MAY 10 1999				32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Frances McKeown  
Baltimore, Maryland 21215-0020

The first part of the paper is devoted to a discussion of the  
 various methods which have been employed for the determination of  
 the rate of reaction. It is found that the most reliable method is  
 the one which involves the measurement of the change in the  
 concentration of the reactants or products. This method is  
 applicable to all reactions, and it is the only one which gives  
 a direct measure of the rate of reaction. The other methods  
 which have been employed are the method of initial rates, the  
 method of half-lives, and the method of integrated rate laws.  
 Each of these methods has its own advantages and disadvantages,  
 and the choice of method depends upon the nature of the reaction  
 and the accuracy required.

The second part of the paper is devoted to a discussion of the  
 factors which influence the rate of reaction. It is found that the  
 rate of reaction is influenced by the concentration of the reactants,  
 the temperature, the presence of a catalyst, and the surface area of  
 the reactants. Each of these factors has a definite effect upon the  
 rate of reaction, and the effect can be explained on the basis of  
 the collision theory.

The third part of the paper is devoted to a discussion of the  
 mechanism of reaction. It is found that the mechanism of reaction  
 is the sequence of steps which lead from the reactants to the products.  
 The mechanism of reaction is important in the study of chemical  
 reactions, and it is the only way in which the rate of reaction can  
 be explained.

The fourth part of the paper is devoted to a discussion of the  
 applications of the study of chemical kinetics. It is found that the  
 study of chemical kinetics has many applications in the field of  
 chemistry, and it is the only way in which the rate of reaction can  
 be explained.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

16180

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MELVIN BERNARD MERRIDITH, SR.</b>						2. Date of Death Month Day Year <b>MAY 03, 1999</b>		3. Time of Death <b>6:00pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>317 LOTS RD.</b>						4b. City, Town, or Location of Death <b>STEVENSVILLE</b>		4c. County of Death <b>QUEEN ANNE</b>	
Funeral Director	5. Social Security Number <b>213-24-1414</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 21, 1929</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>QUEEN ANNE</b>		10c. City, Town or Location <b>STEVENSVILLE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>317 LOTS RD.</b>				10f. Zip Code <b>21619</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>07</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>SEAFOOD</b>			
17. Father's Name (First, Middle, Last) <b>HERMAN MERRIDITH</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>VIOLA TILGHMAN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>FAYE TAYLOR / DAUGHTER</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 SAWMILL LANE GRASONVILLE, MD. 21638</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>UNION WESLEY CEME.</b>		Date <b>5/9/99</b>		20c. Location - City or Town, State <b>CHESTER, MD.</b>		
21. Signature of Funeral Service Licensee <b>Eric L. Dashiell</b>						22. Name and Address of Facility <b>DASHIELL FUNERAL SERVICES 319 E. DOVER ST. EASTON, MD. 21601</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sudden Death</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Eric F. Ciganek, M.D.</b>						29c. License number <b>D35048</b>		29d. Date signed (Month, Day, Year) <b>5/5/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ERIC F. CIGANEK MD 2540 CENTREVILLE, RD. CENTREVILLE, MD. 21617</b>										
31. Date filed (Month, Day, Year) <b>MAY 06 1999</b>		32. Registrar's Signature <b>B. Sparks</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CONFIDENTIAL

1. The first part of the report discusses the general situation of the country and the progress of the revolution. It mentions the importance of the people's participation in the revolutionary process and the need for a united front among the revolutionary forces.

2. The second part of the report deals with the economic situation of the country. It points out that the economy is in a state of crisis and that the government has taken measures to stabilize it. It also mentions the need for further reforms to improve the economic situation.

3. The third part of the report discusses the political situation of the country. It mentions the importance of a democratic system and the need for a constitution. It also mentions the need for a strong executive branch and a powerful judiciary.

4. The fourth part of the report discusses the social situation of the country. It mentions the importance of social justice and the need for reforms to improve the lives of the people. It also mentions the need for a strong social security system.

5. The fifth part of the report discusses the foreign relations of the country. It mentions the importance of maintaining good relations with the neighboring countries and the need for a policy of non-alignment.

6. The sixth part of the report discusses the military situation of the country. It mentions the importance of a strong military and the need for a policy of defense. It also mentions the need for a strong navy and a powerful air force.

7. The seventh part of the report discusses the cultural situation of the country. It mentions the importance of a strong culture and the need for reforms to improve the cultural life of the people. It also mentions the need for a strong education system.

8. The eighth part of the report discusses the environmental situation of the country. It mentions the importance of a strong environment and the need for reforms to improve the environmental situation. It also mentions the need for a strong forest department and a powerful water resources department.

9. The ninth part of the report discusses the health situation of the country. It mentions the importance of a strong health system and the need for reforms to improve the health of the people. It also mentions the need for a strong medical research department and a powerful health services department.

10. The tenth part of the report discusses the overall situation of the country. It mentions the importance of a strong government and the need for a policy of development. It also mentions the need for a strong economy, a strong political system, a strong social system, a strong foreign relations system, a strong military system, a strong cultural system, and a strong environmental system.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FUCHSYA L. O'REAR

2. Date of Death

May

2

Day

1999

Year

3. Time of Death

2:55 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Moran Manor Nursing Home

4b. City, Town, or Location of Death

Westernport

4c. County of Death

Allegany

5. Social Security Number

213-22-3429

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 25, 1921

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Keyser

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

500 Carskadon Lane

10f. Zip Code

26726

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurse's Aide

16b. Kind of Business/Industry

Nursing

17. Father's Name (First, Middle, Last)

Ira Arthur Biser

18. Mother's Name (First, Middle, Maiden Surname)

Tabitha Mae Oates

19a. Informant's Name/Relationship (Type, Print)

William S. O'Rear, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

563 Rose Hill Avenue Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Potomac Memorial Gardens

Date

May 5

20c. Location - City or Town, State

Keyser, WV

21. Signature of Funeral Service Licensee

Bryan L. Snell

22. Name and Address of Facility

Rotruck-Smith Funeral Home

85 S. Main Street Keyser, WV 26726

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Hypotension

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Diabetes mellitus

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

1 day

1 year

&gt; 5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism  
Respiratory Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Annette S. Warrenfeltz, M.D.

29c. License number

D50037

29d. Date signed (Month, Day, Year)

May 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Annette S. Warrenfeltz, M.D.

136 Main Street Westernport, MD 21562

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

99 16182

**Medical Certification: To Be Completed by Physician/Medical Examiner**





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16183

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Benjamin Schutz</b>				2. Date of Death Month <b>May</b> Day <b>1</b> Year <b>1999</b>		3. Time of Death <b>5 P.M.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>245 Deep Water Point Road Unit 10</b>				4b. City, Town, or Location of Death <b>St. Michaels</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>078-07-6734</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 23, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>Illinois</b>		10a. State <b>Maryland</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>St. Michaels</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>245 Deep Water Point Road</b>		10f. Zip Code <b>21663</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Vice President</b>				16b. Kind of Business/Industry <b>Orangeburg Manufacturing Co.</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Benjamin Schutz</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Wager</b>			
	19a. Intendant's Name/Relationship (Type, Print) <b>William B. Schutz, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9539 Quail Hollow Drive, #301 St. Michaels, MD. 21663</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Old St. Joseph's Cemetery</b>		20c. Location - City or Town, State <b>5/6/99 Cordova, Md.</b>	
	21. Signature of Funeral Service Licensee <i>Harrison E. Leonard</i>				22. Name and Address of Facility <b>Harrison E. Leonard Funeral Home 312 S. Talbot St., St. Michaels, Maryland 21663</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic Coronary artery disease years</b> Due to (or as a consequence of): <b>Atrial fibrillation</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cardiovascular disease</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>J. von</i> MD			
	29c. License number <b>10053597</b>				29d. Date signed (Month, Day, Year) <b>5/4/99</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Von Klar, M. D., 800 S. Talbot Street, St. Michaels, Maryland 21663</b>				31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>			
	32. Registrar's Signature <i>J. von</i>				33. Registrar's Signature <i>J. von</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16184

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Erkle J. Sulkowski

2. Date of Death

Month Day Year  
May 8, 1999

3. Time of Death

4:00 am

4a. Facility Name (If not institution, give street and number)

Frostburg Village Nursing Home

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

Funeral  
Director

5. Social Security Number

117-01-4580

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 30, 1915

9. Birthplace (State or Foreign Country)

AK

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Rawlings

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18518 McMullen Highway

10f. Zip Code

21557

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph Birch

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Mae (Simmons)

19a. Informant's Name/Relationship (Type, Print)

Jim Sulkowski-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18518 McMullen Highway Rawlings MD 21557

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cem.

Date

05/10

20c. Location - City or Town, State

Flintstone MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.

Cumberland MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Approximate Interval Between Onset and Death

30 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. occlusion of Coronary artery

"

c. Coronary atherosclerosis

40 years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoid Tumour with metastasis.

Electrolyte abnormalities.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

S.L. Sandhir MD

29c. License number

D 14464

29d. Date signed (Month, Day, Year)

5/10/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. S.L. Sandhir 48 Tarn Terrace Frostburg MD 21532

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7

hes



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16185

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LULU EDITH SETZER				2. Date of Death Month Day Year MAY 5 1999				3. Time of Death 11:50 A.M.		
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 211 12 9110		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) FEB 1 1920		9. Birthplace (State or Foreign Country) PENNSYLVANIA		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location LaVALE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 606 N. 4th STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) JOHN MILTON DEAL				18. Mother's Name (First, Middle, Maiden Summa) ALICE EVORA GARLETS						
	19a. Informant's Name/Relationship (Type, Print) SHIRLEY MELTON/ DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. BOX 913, N. TAZEWEEL, VA 24630						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREENVILLE CEMETERY		Date 5/8/99		20c. Location - City or Town, State GREENVILLE TOWNSHIP, PA				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										4 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Disease										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number D35135			29d. Date signed (Month, Day, Year) 5/11/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS E. CHAPPELL, M.D., 912 SETON DRIVE, CUMBERLAND, MD 21502											
31. Date filed (Month, Day, Year) MAY 10 1999										32. Registrar's Signature 	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) ELIZABETH JEAN SAYGER				2. Date of Death Month Day Year MAY 8 1999		3. Time of Death 19:50	
4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
5. Social Security Number 216-22-5173		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT 18 1924	9. Birthplace (State or Foreign Country) W.VA.
Usual Residence of Decedent							
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 302 ARCH STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RESTAURANT/WAITERSS		16b. Kind of Business/Industry RESTAURANT	
17. Father's Name (First, Middle, Last) THOMAS COLEMAN				18. Mother's Name (First, Middle, Maiden Surname) NELLIE NOGEL			
19a. Informant's Name/Relationship (Type, Print) SANDRA LEWIS DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 349 DORN AVE CUMBERLAND MARYLAND 21502			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY MAY 11 1999		Date MAY 11 1999		20c. Location - City or Town, State CUMBERLAND MARYLAND	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC CANCER OF LUNG Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 4 years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D33280		29d. Date signed (Month, Day, Year) MAY 9, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUNIL K. GUPTA, 625 KENT AVE., SUITE 101, CUMBERLAND, MD 21502							
31. Date filed (Month, Day, Year) MAY 10 1999							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

ELIZABETH SAYGER 216-22-5173

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16187

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Eleanor Stewart		2. Date of Death Month Day Year May 1, 1999		3. Time of Death 7:00 A.M.
	4a. Facility Name (If not institution, give street and number) Residence-217 Columbia Street		4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany
Funeral Director	5. Social Security Number 212-38-6418	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) Oct. 5, 1916
	9. Birthplace (State or Foreign Country) Pennsylvania				
To Be Completed by Funeral Director	10a. State Maryland		10b. County Allegany		10c. City, Town or Location Cumberland
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	10e. Street and Number 217 Columbia Street Apt. #1		10f. Zip Code 21502		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home
	17. Father's Name (First, Middle, Last) Charles Fisher		18. Mother's Name (First, Middle, Maiden Surname) Olive Zembower		
	19a. Informant's Name/Relationship (Type, Print) Charles R. Stewart-Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12807 Woodward Ave. N.E. Cumberland, Md. 21502		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Centenary Cemetery		20c. Location - City or Town, State Cumberland, Maryland
	21. Signature of Funeral Service Licensee Ernest A. Ribby, Jr.		22. Name and Address of Facility Leasure-Stein Funeral Home 230 Baltimore Ave. Cumberland, Md. 21502		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Metastatic adenocarcinoma of uterus with peritoneal carcinomatosis Due to (or as a consequence of): b. Carcinomatosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John N. Mehanna, M.D.		29c. License number D-17526
	29d. Date signed (Month, Day, Year) May, 4, 1999				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John N. Mehanna, M.D. 902 Seton Drive Cumberland, Md. 21502				
31. Date filed (Month, Day, Year) MAY 04 1999		32. Registrar's Signature			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16188

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNIS ROSS SCHROEDER				2. Date of Death Month Day Year MAY 1, 1999		3. Time of Death 3:07 AM		
	4a. Facility Name (If not Institution, give street and number) MEMORIAL HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 426-22-8866		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 10, 1907	9. Birthplace (State or Foreign Country) WEST VIRGINIA	
	Usual Residence of Decedent								
10a. State MD		10b. County HARFORD		10c. City, Town or Location BEL AIR			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 132 WEST BELCREST ROAD				10f. Zip Code 21014		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER			16b. Kind of Business/Industry EDUCATION		
17. Father's Name (First, Middle, Last) SAMUEL ROSS				18. Mother's Name (First, Middle, Maiden Surname) LILA CRITES					
19a. Informant's Name/Relationship (Type, Print) FRANK SCHROEDER/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 WEST BELCREST ROAD, BEL AIR, MD 21014					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HEAVNER CEMETERY		Date 5/5/99		20c. Location - City or Town, State BUCKHANNON, WV			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immadiata Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. AORTIC STENOSIS Due to (or as a consequence of): c. 2 DAYS POST KNEE REPLACEMENT Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death a. <1 HOUR b. 20 YEARS c. 2 DAYS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 			29c. License number D07164		29d. Date signed (Month, Day, Year) MAY 3, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK HARVEY, M.D. - 925 SETON DRIVE, CUMBERLAND, MD 21502									
31. Date filed (Month, Day, Year) MAY 04 1999		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.




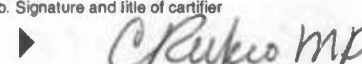

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16189

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Ann Thomas				2. Date of Death Month Day Year April 30 1999		3. Time of Death 12:00P	
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 108-26-8791		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 22, 1917	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland		10b. County Talbot		10c. City, Town or Location Easton	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 312 Prospect Ave.		10f. Zip Code 21601		10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Someone else's home				
17. Father's Name (First, Middle, Last) William Edward Thomas				18. Mother's Name (First, Middle, Maiden Surname) Annie Virginia Harris				
19a. Informant's Name/Relationship (Type, Print) Alponso Kellum (sister)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10479 Council Rd. Cordova, Maryland 21625				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Royal Oak Cemetery		Date 5/4/99		20c. Location - City or Town, State Royal Oak, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601				
23. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D52856		29d. Date signed (Month, Day, Year) 5/1/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia F. Rubio, M.D., 219S. Washington Street, Easton, Maryland 21601								
31. Date filed (Month, Day, Year) MAY 02 1999		32. Registrar's Signature 						

Martha Thomas  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Richard David Taylor</b>				2. Date of Death Month <b>MAY</b> Day <b>4</b> Year <b>1999</b>		3. Time of Death <b>6:00AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
5. Social Security Number <b>028-28-0401</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 27, 1936</b>	
9. Birthplace (State or Foreign Country) <b>MA</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>LaVale</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>120 Mustopthal Drive</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retired Millwright</b>		16b. Kind of Business/Industry <b>Carpenters Local</b>	
17. Father's Name (First, Middle, Last) <b>Millard D. Taylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia (Cummings)</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jo Ellen Taylor</b> <b>wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>120 Mustopthal Drive; LaVale MD 21502</b>			
20a. Manner of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rocky Gap Veterans Cem 5/07/ Flintstone, MD</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Metastatic cancer of prostate G, ure</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>00 83 77</b>		29d. Date signed (Month, Day, Year) <b>MAY 5 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Uriel Velandia, M.D. 902 Seton Drive Cumberland MD 21502</b>							
31. Date filed (Month, Day, Year) <b>MAY 04 1999</b>				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Otha C. VanMeter</b>				2. Date of Death Month Day Year <b>May 10 1999</b>		3. Time of Death <b>2:11</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>215-34-4904</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jul 26, 1937</b>	
	9. Birthplace (State or Foreign Country) <b>WV</b>		10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Wastewater Treatment Pl City -Cumberland</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Wastewater Treatment Pl City -Cumberland</b>			
	17. Father's Name (First, Middle, Last) <b>George VanMeter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa (Rohrbaugh)</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Larry VanMeter son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>309 Franklin Street; Cumberland MD 21502</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Tabor Cemetery</b>			
To Be Completed by Physician/Medical Examiner	20c. Location - City or Town, State <b>5/13/ Spring Gap, MD</b>				21. Signature of Funeral Service Licensee <b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>1 hour</b> <b>3 years</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) <b>May 10 1999</b>			
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>M</b>				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier <b>Donald F. Manger MD</b>				29c. License number <b>105830</b>			
To Be Completed by Physician/Medical Examiner	29d. Data signed (Month, Day, Year) <b>May 10 1999</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donald F. Manger 11600 Bedford Road NE CUMBERLAND MD 21502</b>			
	31. Date filed (Month, Day, Year) <b>MAY 11 1999</b>				32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

ms



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16192

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CATHERINE EMMA WILSON				2. Date of Death Month Day Year APRIL 29 1999				3. Time of Death 9:40 AM	
	4a. Facility Name (If not institution, give street and number) MEMORIAL HOSPITAL & MEDICAL CENTER				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 220-24-3368		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) JULY 10 1906		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent				10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 308 MT. VIEW DRIVE				10f. Zip Code 21502	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 6	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MICROBIOLOGIST				16b. Kind of Business/Industry MICROBIOLOGIST				17. Father's Name (First, Middle, Last) ORION OLIVER WILSON	
	18. Mother's Name (First, Middle, Maiden Surname) LOUISE CATHERINE PRESSMAN				19a. Informant's Name/Relationship (Type, Print) ORVILLE SHIREY NEPHEW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 IRONMASTER COURT THURMONT, MARYLAND 21788	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT				20b. Place of Disposition (Name of cemetery, crematory or other place) ROSE HILL				20c. Location - City or Town, State MAY 5 1999 CUMBERLAND MARYLAND	
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Intra abdominal infection</i> Due to (or as a consequence of): b. <i>perforated peptic ulcer</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Physician /Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>N.A. Ranjithan</i>				29c. License number D 19318	
	29d. Date signed (Month, Day, Year) 5/3/99				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.A. RANJITHAN M.D., 517 OLDTOWN ROAD, CUMBERLAND, MD 21502				31. Date filed (Month, Day, Year) MAY 04 1999	
	32. Registrar's Signature <i>[Signature]</i>									





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ethel V. Walker

2. Date of Death

Month Day Year  
May 5, 1999

3. Time of Death

6:25 AM

4a. Facility Name (If not institution, give street and number)

Cumberland Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

5. Social Security Number

213-24-6456

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 4, 1899

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegheny

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

229 Baltimore St., Apt. # 505

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Grant McDonald

18. Mother's Name (First, Middle, Maiden Surname)

Mae (Swisher)

19a. Informant's Name/Relationship (Type, Print)

Robert May

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Helen St., LaVale, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maysville Cemetery

Date

5/7/99

20c. Location - City or Town, State

Maysville, WV

21. Signature of Funeral Service Licensee

William S. Kight

22. Name and Address of Facility

Kight Funeral Home  
309-311 Decatur St., Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYELODYSPLASIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

12/94

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Qamar MD

29c. License number

023371

29d. Date signed (Month, Day, Year)

05-05-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Qamar ul Zaman, M.D.  
625 Kent Avenue, Suite 102, Cumberland, Maryland 21502

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ARTHUR AYERS</b>		2. Date of Death Month <b>May</b> Day <b>15th</b> Year <b>1999</b>		3. Time of Death <b>1:30 pm</b>
4a. Facility Name (If not institution, give street and number) <b>LEVINDALE HEBREW GERIATRIC CENTER</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>25-76-5287</b>	6. Sex <b>M</b> <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Jan. 1, 1916</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Owings Mills</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>Rosewood Lane</b>		10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Patient of State Institution</b>		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>Arthur N. Ayers</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Washington</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Ed Johnston Social Worker</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21117</b> <b>Rosewood Center, Rosewood Lane, Owings Mills, MD</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Thomas Cemetery</b>		20c. Location - City or Town, State <b>Owings Mills, MD</b>
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Eline Funeral Home</b> <b>11824 Reisterstown Rd.</b> <b>Reisterstown, MD 21136</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death) a. <b>acute cardiopulmonary arrest</b> Due to (or as a consequence of):				
b. <b>pneumonia</b> Due to (or as a consequence of):				
c. Due to (or as a consequence of):				
d. Due to (or as a consequence of):				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>quadraplegic</b> <b>Seizure Disorder</b> <b>dysphagic</b> <b>anemic - iron deficiency</b> <b>dearthritis</b> <b>mental retardation</b>				
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <i>[Signature]</i> <b>Consult</b>		29c. License number <b>D:44907</b>		29d. Date signed (Month, Day, Year) <b>May 16th 1999</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2434 W. Belvedere Ave</b> <b>Baltimore, MD</b> <b>21215-5255</b>				
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature <i>[Signature]</i> <b>B. Sparks</b>		

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature and date: 000 03 JAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edna Frieda Allen

2. Date of Death

Month  
May

Day  
15

Year  
1999

3. Time of Death

11:10 PM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Forest Hill

4b. City, Town, or Location of Death

Forest Hill

4c. County of Death

Harford

5. Social Security Number

217-22-4117

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 18, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1620 Michelle Ct.

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNKNOWN

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

home

17. Father's Name (First, Middle, Last)

Fred Mosher

18. Mother's Name (First, Middle, Maiden Surname)

Mary Frischknecht

19a. Informant's Name/Relationship (Type, Print)

Edna L. Given

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Bell Clapp Cir. Sparks, Maryland 21152

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Luth. Ch. Cemo.

Date

May 19, 1999

20c. Location - City or Town, State

Parkville, Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel  
2325 York Rd. Timonium, Maryland 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. progressive dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David S. Dunn

29c. License number

D32291

29d. Date signed (Month, Day, Year)

May 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Dunn 615 W. MacPhail

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

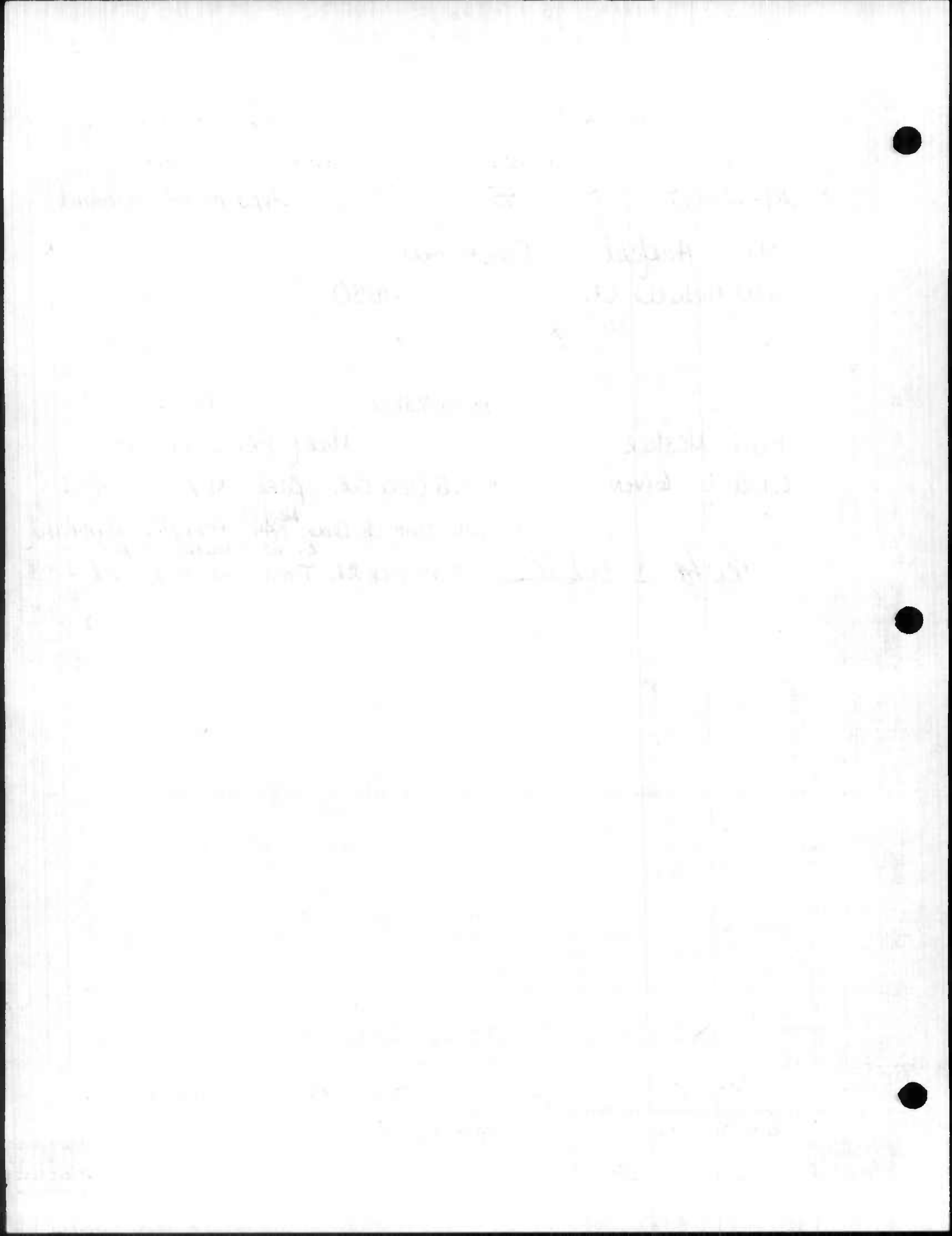
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16196

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARSINEH A. ALLEN

2. Date of Death

Month Day Year  
MAY 19, 1999

3. Time of Death

7:15 p.m.

4a. Facility Name (If not institution, give street and number)

HAMILTON GENESIS NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-34-0249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Apr. 2, 1915

9. Birthplace (State or Foreign Country)

IRAQ

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

215 ALLENDALE STREET

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

ARTASHAS KASPIAN

18. Mother's Name (First, Middle, Maiden Surname)

SANTINIC TORBAKIAN

19a. Informant's Name/Relationship (Type, Print)

EDWARD P. ALLEN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3681 FREDONIA DRIVE, LOS ANGELES, CA. 90068

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. OLIVET CEMETERY

Date

5/21/99

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY & ZEILER INC. FUNERAL HOME  
1901 EASTERN AVENUE, BALTIMORE, MD. 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive Pulmonary Disease

Due to (or as a consequence of):

b. Diabetes

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Degenerative Joint Disease

Hiatal Hernia with reflux

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARIL A. HATHAM, MD, 821 N. EUTAW ST Suite 304, Balt. MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMENDED #17 PER FH G771 5/20/99 AH

99 16197

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN BERGERSON</b>				2. Date of Death Month <b>MAY</b> Day <b>18</b> Year <b>1999</b>		3. Time of Death <b>5:40PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>HEBREW HOME OF GREATER WASHINGTON</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>215-09-0292</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>FEB 22 1912</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>MONTGOMERY</b>	10c. City, Town or Location <b>ROCKVILLE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>6111 MONTROSE ROAD 4 SOUTH</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SOCIAL SECURITY APPEALS</b>			16b. Kind of Business/Industry <b>US GOVERNMENT</b>			
	17. Father's Name (First, Middle, Last) <b>ISAAC EMBER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY CASMEL</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ERIC BERGERSON/ SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11812 BEEKMAN PLACE POTOMAC, MD 20854</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH TFILOH CONGREGATION</b>		Date <b>5/18/99</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ACUTE MYOCARDIAL INFARCTION Sudden</b> Due to (or as a consequence of): <b>b. —</b> Due to (or as a consequence of): <b>c. —</b> Due to (or as a consequence of): <b>d. —</b>								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA, VASCULAR</b>						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number <b>D 15084</b>		29d. Date signed (Month, Day, Year) <b>May 17, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D.D. PATEL, M.D. 6121 Montrose RD, Rockville, MD 20852</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Handwritten signature or initials

1941 U.S. 7-11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

89 16198

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gwendolyn Budd</b>				2. Date of Death Month Day Year <b>05 18 99</b>		3. Time of Death <b>6:00pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical Center Baltimore, Md</b>				4b. City, Town, or Location of Death <b>Baltimore, Md</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-30-9286</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs, last birthday) <b>67</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>MAY 30, 1931</b>	9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>		
	Usual Residence of Decedent							
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>4416 MOUNTVIEW ROAD</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12+ GRADE</b> College (1-4or 5+) <b>1-YR.</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MEAT INSPECTOR</b>		16b. Kind of Business/Industry <b>STATE GOVERNMENT</b>		
17. Father's Name (First, Middle, Last) <b>ELLIOTT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FORD MERLIN GRIFFIN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN FORD MULLINS (SISTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3517 MERLIN COURT, MULLINS, S.C. 29574</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLCREST MEMORIAL GARDENS</b>		20c. Location - City or Town, State <b>05-26-99 MULLINS, SOUTH CAROLINA</b>		20d. Date		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR FUNERAL HOME 2140 N. FULTON AVENUE, BALTO, MD. 21217</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Multisystem organ failure</b> Due to (or as a consequence of): <b>3 days</b> b. <b>Intraabdominal abscess</b> Due to (or as a consequence of): <b>2 wks</b> c. <b>Gastrointestinal/Anastomotic leak</b> Due to (or as a consequence of): <b>3 wks</b> d. <b>Diverticulitis</b> Due to (or as a consequence of): <b>3 months</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic renal insufficiency</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Describe how Injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Julius D. Cheng Trauma Fellow</b>				29c. License number <b>P12379</b>		29d. Date signed (Month, Day, Year) <b>May 18, 1999.</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Julius D. Cheng; 22 S. Greene St., Baltimore, Md. 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

Please Type or Print in Black Indellible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16199

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Margaret R. Britt</b>				2. Date of Death Month Day Year <b>May 18, 1999</b>		3. Time of Death <b>5:00 A.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Future Care Cherrywood</b>				4b. City, Town, or Location of Death <b>Reisterstown</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>172-28-0039</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 12, 1909</b>	
9. Birthplace (State or Foreign Country) <b>PA.</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3627 Waterwheel Square</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th Grade</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Edward Regis Kittredge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Veronica Knox</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Loretta Britt</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3627 Waterwheel Square; Randallstown, Maryland 21133</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LaFayette Memorial Park</b>		20c. Location - City or Town, State <b>Brier Hill, PA.</b>		Date <b>5/22/99</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CARDIAC ARREST</b> Due to (or as a consequence of): <b>b. ASCVD</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>20 years</b>  Approximate Interval Between Onset and Death <b>1/2 hr</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>D13999</b>		29d. Date signed (Month, Day, Year) <b>5-18-99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MB Penniman MD 5400 OLD COUNTRY RD 21133</b>							
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16200

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clarence H. Bryant</b>				2. Date of Death Month Day Year <b>MAY 17, 1999</b>		3. Time of Death <b>12:45 pm</b>		
	4a. Facility Name (If not Institution, give street and number) <b>VAMHCS FORT HOWARD</b>				4b. City, Town, or Location of Death <b>FORT HOWARD</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>104-12-5369</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 1, 1920</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>								
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2641 Loyola Northway</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sheet Metal Worker Private Company</b>			16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) <b>Randolph Bryant</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rose Distance</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Mable Bryant (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2641 Loyola Northway Balto, Md. 21215</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		20c. Date <b>5/24/99</b>		20d. Location - City or Town, State <b>Owings Mills, Md.</b>	
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CANCER, PROSTATE with Metastasis</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>									
Approximate Interval Between Onset and Death <b>1 MONTH</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Status-post Pneumonectomy for Lung Cancer (1978), Status-post Right PAROTID RESECTION, and Status-post Radiation Treatment for Cancer (1992)</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Aurora C. Tan, M.D.</b>		29c. License number <b>D14958</b>		29d. Date signed (Month, Day, Year) <b>MAY 17, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Aurora C. Tan, MD. 9600 North Point Road, Fort Howard, MD. 21052</b>									
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <b>B. Sparks</b>					

CLARENCE BRYANT

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

WRC  
99-2826-510  
CHRISTOPHER  
BEAM ITEMS: #23 PART I, 27, 28A-F PER MEO G771 5-24-99 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHRISTOPHER JOSEPH BEAM</b>				2. Date of Death Month Day Year <b>MAY 16, 1999</b>		3. Time of Death <b>3:23 PM.</b>			
	4a. Facility Name (If not institution, give street and number) <b>DELUXE MOTEL ROOM 27 6401 PULASKI HWY.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death			
Funeral Director	5. Social Security Number <b>212-62-5287</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>41</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>October 29, 1957</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKVILLE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3331 Woodside Ave</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF EMP - OWNER</b>			16b. Kind of Business/Industry <b>PACKAGING AND Moving Company</b>				
	17. Father's Name (First, Middle, Last) <b>CLARENCE C. BEAM, JR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>AUDREY G. SHECKELS</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>AUDREY G. BEAM</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3331 Woodside Ave. Parkville, Maryland 21234</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		Date <b>MAY 20 1999</b>		20c. Location - City or Town, State <b>PARKVILLE MARYLAND</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE MARYLAND 21234</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE COCAINE AND NARCOTIC INTOXICATION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of):  <b>c. _____</b> Due to (or as a consequence of):  <b>d. _____</b>								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 5-16-99</b>		28b. Time of Injury <b>Found: 3:20 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>FOUND IN MOTEL ROOM</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>6401 PULASKI HIGHWAY BALTIMORE, MARYLAND</b>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY 17, 1999</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>										
State Registrar		31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

That is the

May 2 1960

WRC  
99-2812-510  
FRANCES  
BARONETTE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 16202

ITEMS: #23 PART I, II, 27 PER MEO G772 6-7-99 WR.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>FRANCES L. BARONETTE</b>		2. Date of Death Month Day Year <b>MAY 15, 1999</b>		3. Time of Death <b>6:08 PM.</b>	
4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>072-46-7703</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.	
8. Date of Birth Month Day Year <b>July 19, 1957</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>			
10a. State <b>New York</b>		10b. County <b>Queens</b>		10c. City, Town or Location <b>St. Albans</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>194-29 116th Avenue</b>		10f. Zip Code <b>11412</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>own Home</b>	
17. Father's Name (First, Middle, Last) <b>JOE T. ARVIN, SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Estelle Thompson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>NOEL BARONETTE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>194-29 116th Ave. St. Albans N.Y. 11412</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Union Cemetery 15/22 Keysville VA</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <b>Sharon Adams Jones</b>		22. Name and Address of Facility <b>MARSHALL W. JONES JR. F.H. P.A. 4101 E.monds on Ave. BALD MD 21229</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>DILATED CARDIOMYOPATHY</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>MORBID OBESITY</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>MAY 16, 1999</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>			
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature <b>[Signature]</b>			

*Handwritten signature*

MAY 5 1963



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16203

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Adam E. Brulinski				2. Date of Death Month Day Year MAY 15 1999		3. Time of Death 4:16 PM																											
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A																											
Funeral Director	5. Social Security Number 215-16-2173		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) July 31, 1923																											
	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																											
To Be Completed by Funeral Director	10e. Street and Number 5201 Anthony Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Longshoreman		16b. Kind of Business/Industry Local #333																											
	17. Father's Name (First, Middle, Last) Celestyn Brulinski				18. Mother's Name (First, Middle, Maiden Surname) Marcella Grabowski																													
	19a. Informant's Name/Relationship (Type, Print) Jean H. Brulinski				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 Anthony Avenue Baltimore, Maryland 21206																													
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary Cemetery		Date 5/19/99		20c. Location - City or Town, State Baltimore, Maryland																											
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206																													
	23a. Part I: Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>CHRONIC LYMPHOCYTIC LEUKEMIA</td> <td>9 YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>METASTATIC SQUAMOUS CELL CARCINOMA</td> <td>4 YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>ADENOCARCINOMA OF THE COLON</td> <td>5 YEARS</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> <tr> <td colspan="2"></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	CHRONIC LYMPHOCYTIC LEUKEMIA	9 YEARS	Due to (or as a consequence of):			b.	METASTATIC SQUAMOUS CELL CARCINOMA	4 YEARS	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	ADENOCARCINOMA OF THE COLON	5 YEARS	Due to (or as a consequence of):			d.					
	Immediate Cause (Final disease or condition resulting in death)	a.	CHRONIC LYMPHOCYTIC LEUKEMIA	9 YEARS																														
Due to (or as a consequence of):																																		
b.		METASTATIC SQUAMOUS CELL CARCINOMA	4 YEARS																															
Due to (or as a consequence of):																																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	ADENOCARCINOMA OF THE COLON	5 YEARS																															
	Due to (or as a consequence of):																																	
	d.																																	
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEEP VENOUS THROMBOSIS HYPERTENSION</td> <td colspan="4">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="2">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEEP VENOUS THROMBOSIS HYPERTENSION				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEEP VENOUS THROMBOSIS HYPERTENSION				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																														
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																												
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																														
28f. Location (Street and Number or Rural Route Number, City or Town, State)																																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																		
29b. Signature and title of certifier 				29c. License number AT 243 89 46		29d. Date signed (Month, Day, Year) MAY 15, 1999																												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD A. ELLIOTT, M.D. 201 EAST UNIVERSITY PARKWAY BALTIMORE, MARYLAND 21218																																		
31. Date filed (Month, Day, Year) MAY 20 1999		32. Registrar's Signature 																																





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

ITEMS: #23 PART 1, 27 PER MEO G771 5-24-99 WRT

Reg. No. 99 16204

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GARY LESLIE CASH SR.</b>				2. Date of Death Month Day Year <b>MAY 14, 1999</b>		3. Time of Death <b>0128 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>2603 EAST OLIVER STREET</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>215-42-9710</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>53</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 29, 1946</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>						
To Be Completed by Funeral Director	10e. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2603 E. OLIVER STREET</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9TH GRADE</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOME IMPROVEMENT</b>		16b. Kind of Business/Industry <b>SELF-EMPLOYED</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JOHNNY CASH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MATTIE SOLOMON</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>CAROLYN HARRIS (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1329 SHARON ACRE RD, FOREST HILL, MD. 21050</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>MD-20-99 BALTIMORE, MARYLAND</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO., MD. 21217</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>						Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner	28e. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>MAY, 14, 1999</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>						
State Registrar	31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

AND



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16205

WILLIAM CREWS May 17, 1999 2:30 p.m.

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>WILLIAM RANDOLPH CREWS</b>		2. Date of Death Month <b>MAY</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>2:30 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS</b>		4b. City, Town, or Location of Death <b>TIMONIUM</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>219-52-7257</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>JAN. 30, 1949</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
10a. State <b>MARYLAND</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4330 BLAKELY AVENUE</b>		10f. Zip Code <b>21236</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>YEARS</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>INDEPENDENT TRUCK DRIVER</b>		16b. Kind of Business/Industry <b>SELF-EMPLOYED</b>	
17. Father's Name (First, Middle, Last) <b>WILLIAM B. CREWS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>BONNIE MAE CHRISTIAN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>BARBARA CREWS (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4330 BLAKELY AVENUE BALTIMORE MD. 21236</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Location - City or Town, State <b>OWINGS MILLS MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME</b> <b>2140 N. FULTON AVE. BALTO. MD. 212</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. BRAIN TUMOR</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 	
29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>5/18/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>		31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 	



Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)  
Charlotte May Carr

2. Date of Death  
Month: May, Day: 18, Year: 1999

3. Time of Death  
6:00 AM

4a. Facility Name (If not institution, give street and number)  
Manor Care Ruxton

4b. City, Town, or Location of Death  
Towson

4c. County of Death  
Baltimore Co.

5. Social Security Number  
214-22-0788

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
91 Yrs.

8. Date of Birth (Month, Day, Year)  
May 01, 1908

9. Birthplace (State or Foreign Country)

10a. State  
Maryland

10b. County  
Baltimore Co.

10c. City, Town or Location  
Lutherville

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12): 12 College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Home Maker

16b. Kind of Business/Industry  
Own Home

17. Father's Name (First, Middle, Last)  
Charles Latimer Landes

18. Mother's Name (First, Middle, Maiden Surname)  
Carrie Ellen Warner

19a. Informant's Name/Relationship (Type, Print)  
Mr. William J. Delcher, III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
4617 Long Green Road Glen Arm, Maryland 21057-9735

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)  
Lorraine Park Cemetery

20c. Location - City or Town, State  
5/22/1999 Woodlawn, Maryland

21. Signature of Funeral Service Licensee  
Jeffrey L. Gair

22. Name and Address of Facility  
Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death)  
a. CONGESTIVE HEART FAILURE  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury  
M

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)  
1 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier  
James G. Ebeling, M.D.

29c. License number  
D 34827

29d. Date signed (Month, Day, Year)  
5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
James G. Ebeling, M.D. 7401 Osler Drive Towson, Maryland 21204

31. Date filed (Month, Day, Year)  
MAY 20 1999

32. Registrar's Signature  
B. Sparks

State Registrar

*Handwritten signature*

MAY 5 1988



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16207

Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carrie M. Cureton</b>				2. Date of Death <b>May 17, 1999</b>		3. Time of Death <b>907 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Maryland General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-16-3346A</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>98</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 16, 1900</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>301 McMechen St. apt. 319</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Howard Robinson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Tyler</b>				
19a. Informant's Name/Relationship (Type, Print) (Grandson) <b>Mr. James Toliver</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>303 Gwynn Ave. Balto. Md. 21229</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn</b>		20c. Location - City or Town, State <b>5/21/99 Howard Co. Md.</b>		20d. Date		
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. <b>Ventricular Arrhythmia</b> Due to (or as a consequence of):</p> <p>b. <b>Myocardial Infarction</b> Due to (or as a consequence of):</p> <p>c. <b>Congestive Heart Failure</b> Due to (or as a consequence of):</p> <p>d.</p> </div> </div>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner		10. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					25. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier <b>St. Schwartz</b>		29c. License number <b>P 10699</b>		29d. Date signed (Month, Day, Year) <b>May 17, 1999</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Steven Schwartz, m.d. - Maryland General Hospital</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature <b>Bruce B. Sparks</b>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Carrie Cureton  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/  
Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16208

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MURRAY CARWILE</b>				2. Date of Death Month Day Year <b>MAY 19 1999</b>		3. Time of Death <b>4:45am</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BAITIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>248-42-8490</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11-8-1913</b>		9. Birthplace (State or Foreign Country) <b>NEWBERRY, SC</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BAITIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3215 BRIGHTON STREET</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CEMENT MASON</b>			16b. Kind of Business/Industry <b>LOCAL 43</b>	
17. Father's Name (First, Middle, Last) <b>WASH CARWILE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EDNA CARWILE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>DARLENE JONES (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3215 BRIGHTON ST, BAITIMORE, MD 21216</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CRESTLAWN CEMETERY</b>		20c. Location - City or Town, State <b>5-24-99 ELLICOTT CITY, MD</b>		
21. Signature of Funeral Service Licensee <i>Willie E. Howell</i>				22. Name and Address of Facility <b>LEROY O DYETT &amp; SON FUNERAL HOME</b> <b>4600 LIBERTY HIGHT AVE. BALTO, MD 21207</b>				
23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) a. <i>multiple Cerebral Vascular accidents</i> Due to (or as a consequence of): b. <i>Gastrointestinal Bleeding</i> Due to (or as a consequence of): c. <i>Peripheral Vascular disease</i> Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Shirance L. Lamb no</i>				29c. License number <b>D37203</b>		29d. Date signed (Month, Day, Year) <b>May 19th 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Shirance L. Lamb no. Bon Secours Hospital, Balto. md</i>								
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <i>Shirance L. Lamb</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

11



WATSON, J. W. 1909

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>GRACE VIOLA CORBIN</b>				2. Date of Death Month <b>May</b> Day <b>19</b> Year <b>1999</b>		3. Time of Death <b>5:50AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Futurecare Cherrywood</b>				4b. City, Town, or Location of Death <b>Reisterstown</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>214-26-1917</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 13, 1920</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>337 Bentley Park Lane</b>		10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>William A. Bosley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Julia Westfall</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Joyce C. Bloom Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>337 Bentley Park Lane, Reisterstown, MD 21136</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Falls Rd. Methodist Cem.</b>		20c. Location - City or Town, State <b>Butler, MD</b>		20d. Date <b>5/21/99</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Renal Insufficiency</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>						Approximate Interval Between Onset and Death <b>5 yrs</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>[Signature] MD</b>				29c. License number <b>D47683</b>		29d. Date signed (Month, Day, Year) <b>5/19/99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Raymond Miller 25 Main Street Suite 200 Reisterstown MD</b>							
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

*Handwritten signature*

CHIEF U.S. MAIL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16210

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BLANCHE DOROTHY CRABILL</b>						2. Date of Death Month Day Year <b>May 14 1999</b>		3. Time of Death <b>4:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>MARINER HEALTH - BEL AIR</b>						4b. City, Town, or Location of Death <b>BEL AIR</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>212-28-5506</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>NOV 26, 1913</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>PARKVILLE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>9108 SATYR HILL</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TELEPHONE OPERATOR</b>			16b. Kind of Business/Industry <b>HEALTH CARE</b>		
	17. Father's Name (First, Middle, Last) <b>THOMAS PATRICK LYNCH</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>BLANCHE KURRLE</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>CLENDIA PRICE, DAUGHTER</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9108 SATYR HILL PARKVILLE, MD 21234</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARK WOOD CEMETERY</b>		Date <b>MAY 15, 1999</b>		20c. Location - City or Town, State <b>PARKVILLE, MD</b>		
	21. Signature of Funeral Service Licensee <i>Krischa S. Wells</i>						22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 5800 HARFORD RD. PARKVILLE, MD 21234</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>now insulin dependent Diabetes mellitus hypercholesterolemia.</b>									
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D28136</b>		29d. Date signed (Month, Day, Year) <b>5-14-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>615 W. Main St. Bel Air MD 21014</b>										
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <i>[Signature]</i>						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 16211

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances L. Conwell

2. Date of Death

Month Day Year  
May 15, 1999

3. Time of Death

11:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2010 Larkhall Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

213-28-8214

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
9/9/1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2010 Larkhill Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

U.S.F. G.

17. Father's Name (First, Middle, Last)

John Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Fanny Harriman

19a. Informant's Name/Relationship (Type, Print)

Debra Hayes

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1958 Frames Road Baltimore, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley

Date

5/20/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Hypertensive cardiovascular disease*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ch. Shing Chen MD

29c. License number

0-18151

29d. Date signed (Month, Day, Year)

5-19-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

98 N. BROADWAY BALTIMORE MD 21231 - DR. CHI SHING CHEN

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



MARTHA  
DASHOFF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16212

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA I. DASHOFF				2. Date of Death Month Day Year MAY 15, 1999		3. Time of Death 8:52 P.M.	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212-07-2136		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR. 3, 1908	
	9. Birthplace (State or Foreign Country) MD							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3601 CLARKS LANE #520				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER		16b. Kind of Business/Industry SCRAP METAL	
	17. Father's Name (First, Middle, Last) BENJAMIN JACOBS				18. Mother's Name (First, Middle, Maiden Surname) JENNIE GOLDSMITH			
	19a. Informant's Name/Relationship (Type, Print) BRIAN DASHOFF / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7202 VERBENA ROAD - BALTIMORE, MD 21209			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BETH JACOB CEMETERY		Date 5/18/99		20c. Location - City or Town, State FINKSBURG, MD	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208			
	Physician /Medical Examiner	23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Choking</u> Due to (or as a consequence of):						
b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertensive Atherosclerotic Cardiovascular Disease</u> <u>Hiatal Hernia</u>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 5/15/99		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Nursing Home				28d. Describe how injury occurred Subject choked on Food			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) 2434 W. Belvedere Ave							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) MAY 16, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LAFON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) MAY 20 1999				32. Registrar's Signature <i>[Signature]</i>			

Wash. D. C. 20540  
RECEIVED 6-10-64

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16213

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDWIN LEWIS FRITH

2. Date of Death

Month Day Year  
May 16 1999

3. Time of Death

07:46 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SENAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

083-16-7349

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC 11, 1921

9. Birthplace (State or Foreign Country)

BRITISH WEST INDIES

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2509 GAINSFORD ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ENGINEERING SUPERVISOR

16b. Kind of Business/Industry

TELECOMMUNICATION

17. Father's Name (First, Middle, Last)

EDWIN ROBERT FRITH

18. Mother's Name (First, Middle, Maiden Surname)

HELEN MABEL JONES

19a. Informant's Name/Relationship (Type, Print)

ANN F. FRITH, SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2509 GAINSFORD RD. TIMONIUM, MD. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DULANEY VALLEY MEM. GDNS.

Date

MAY 19,

20c. Location - City or Town, State

TIMONIUM, MD.

21. Signature of Funeral Service Licensee

*David S. Wells*

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infarction

Due to (or as a consequence of):

b.

Heart failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1

1

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Basal Cell Carcinoma

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*David Parker MD*

29c. License number

RES-600

29d. Date signed (Month, Day, Year)

May, 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID PARKER SENAI HOSPITAL OF BALTIMORE BALTIMORE, MARYLAND 21205

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

*P. Sparks*

State  
Registrar

13125 295-9134  
Pl. Knowles Frith, Edwin  
Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

ITEMS: #23 PART I, 27 PER MEO G771 5-25-99 WR.

Reg. No. 99 16214

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Eli Allen Fitzhugh</b>		2. Date of Death Month Day Year <b>May 3, 1999</b>		3. Time of Death <b>3:00 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>414 Hiddenbrook Drive</b>		4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
5. Social Security Number <b>212-55-0591</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>0</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>February 27, 1999</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>	
10e. Street and Number <b>414 Hiddenbrook Drive</b>		10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>"NA"</b> College (1-4 or 5+) <b>"NA"</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>"NA"</b>	
16b. Kind of Business/Industry <b>"NA"</b>		17. Father's Name (First, Middle, Last) <b>"Unknown"</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jamie Lea Fitzhugh</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Raymond W. Fitzhugh Grandfather</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>311 William Drive Benson, North Carolina 27504</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Columbia Memorial Park</b>		20c. Location - City or Town, State <b>05/07/99</b> <b>Clarksville, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SUDDEN INFANT DEATH SYNDROME</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier 		29c. License number <b>O.C.M.B</b>		29d. Date signed (Month, Day, Year) <b>May 4, 1999</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Md 21201</b>					
31. Date filed <b>MAY 20 1999</b>		32. Registrar's Signature 			

State  
Registrar

Handwritten signature and date: 2001 04 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 16215

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen P. George				2. Date of Death Month Day Year 5 15 99				3. Time of Death 10:00 PM			
	4a. Facility Name (If not institution, give street and number) 6633 Charlesway				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore Co.			
Funeral Director	5. Social Security Number 027-18-7477		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) May 10, 1925		9. Birthplace (State or Foreign Country) Springfield, Mass.			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 6633 Charlesway				10f. Zip Code 21204		10g. Citizen of What Country? United States of America					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 04		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administration				16b. Kind of Business/Industry Housing Authority of Baltimore City					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James Pappaioanou				18. Mother's Name (First, Middle, Maiden Surname) Rita Raverta							
	19a. Informant's Name/Relationship (Type, Print) Marguerite Pappaioanou, Ph.D (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 East Redwood Street Baltimore, Maryland 21201							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox Cemetery		20c. Date 5/21/1999		20d. Location - City or Town, State Woodlawn, Maryland					
	21. Signature of Funeral Service Licensee <i>Michael J. Smith</i>				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiac tamponade with Hemopericardium</i> Due to (or as a consequence of): b. <i>Left Ventricular rupture</i> Due to (or as a consequence of): c. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death minutes 3 to 4 days	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
											24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
											24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, MD 21216	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <i>A. C. Alevisatos, MD</i>	
State Registrar	29c. License number D0000359		29d. Date signed (Month, Day, Year) 5/18/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. C. ALEVISATOS, MD 301 ST. PAUL Place Baltimore, Md							
	31. Date filed (Month, Day, Year) MAY 20 1999		32. Registrar's Signature <i>B. Sparks</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible.

Handwritten text, mostly illegible due to fading. Some words like "The", "and", "of" are visible.

Handwritten signature or name.

1921 U.S. YEAR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16216

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>CARNEISHA OSHAY GARRISON</b>		2. Date of Death Month Day Year <b>APRIL 16 99</b>		3. Time of Death <b>12:50 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death
5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>APRIL 15 99</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>FRUITLAND</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>216 POPLAR STREET APT.-103</b>			10f. Zip Code <b>21826</b>		10g. Citizen of What Country? <b>U.S.A</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry
17. Father's Name (First, Middle, Last) <b>JERMAINE GARRISON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>DOORIS McBRIDE</b>		
19a. Informant's Name/Relationship (Type, Print) <b>DOORIS McBRIDE (MOTHER)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>216 POPLAR STREET APT. - 103 FRUITLAND, MO. 21826</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SPRINGHILL MEM. GARDEN</b>		20c. Location - City or Town, State <b>4/27/99 HEBRON, MD.</b>	
21. Signature of Funeral Service Licensee <b>GLADYS B. STEWART</b>			22. Name and Address of Facility <b>STEWART FUNERAL HOME 821 WEST RD. SALISBURY, MD. 21801</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>RESPIRATORY INSUFFICIENCY</b> Due to (or as a consequence of):  b. <b>EXTREME PREMATURITY 24 WEEKS GESTATION</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.					Approximate Interval Between Onset and Death <b>1 HOUR 36 MINUTES</b> <b>1 HOUR 36 MINUTES</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTIPLE CONGENITAL ANOMALIES</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Mark Damian Harris MD</b>		29c. License number <b>D0029866</b>		29d. Date signed (Month, Day, Year) <b>APRIL 16 99</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARK DAMIAN HARRIS MD</b>					
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature <b>G. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16217

ITEM #24a PER MD G771 5-25-99 WR.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Jean Reed Graybeal</b>				2. Date of Death Month Day Year <b>April 18 1999</b>		3. Time of Death <b>2:15 am</b>											
4a. Facility Name (If not institution, give street and number) <b>108 W. Gordon Street</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>											
5. Social Security Number <b>216-12-3009</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>80 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 3, 1918</b>											
9. Birthplace (State or Foreign Country) <b>Maryland</b>																	
Usual Residence of Decedent																	
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>		10d. Inside City Limits <b>1 Yes 2 No</b>											
10e. Street and Number <b>108 W. Gordon Street</b>				10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>U.S.A.</b>											
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b>		14. Race - American Indian, Black, White, etc. <b>white</b>											
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 College (1-4or 5+) 3</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home maker</b>		16b. Kind of Business/Industry <b>Own home</b>											
17. Father's Name (First, Middle, Last) <b>Charles Reed</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie L. Worthington</b>													
19a. Informant's Name/Relationship (Type, Print) <b>John Graybeal/son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1019 Mountain View Avenue, Mountain View, CA 94040</b>													
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Date</b>		20c. Location - City or Town, State											
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</b>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>Cerebrovascular Accident</b></td> <td rowspan="4">                 Approximate Interval Between Onset and Death   <b>5 days</b> </td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Cerebrovascular Accident</b>	Approximate Interval Between Onset and Death  <b>5 days</b>	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Cerebrovascular Accident</b>	Approximate Interval Between Onset and Death  <b>5 days</b>														
	b.	Due to (or as a consequence of):															
	c.	Due to (or as a consequence of):															
	d.	Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Lung Cancer - Non-small cell (recurrent). - Coronary Artery Disease.</b>						23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>											
24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>															
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		28. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>															
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>											
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>																	
29b. Signature and title of certifier <b>J. Kevin Lynch MD</b>				29c. License number <b>D35012</b>		29d. Date signed (Month, Day, Year) <b>April 30, 1999</b>											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014</b>																	
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <b>B. Sparks</b>													

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified in writing.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

ITEM#26 PER PHYSN. G771 5-20-99 J.A.

99 16218

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Risa H. Glascoe</b>				2. Date of Death Month Day Year <b>April 21 1999</b>		3. Time of Death <b>1:25 am</b>	
4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>				4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>220-38-9148</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 17, 1913</b>	
9. Birthplace (State or Foreign Country) <b>unknown</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2300 Dulaney Valley Road</b>				10f. Zip Code <b>21093</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unknown</b>		16b. Kind of Business/Industry <b>unknown</b>	
17. Father's Name (First, Middle, Last) <b>Ali Glascoe</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Besida Meekins</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Sharon Blanchard/neice</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 Canoga Place, Baltimore, MD 21236</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Chronic Obstructive Airways Disease</b></p> <p>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%; border-left: 1px dashed black; padding-left: 10px;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>							
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>4/23/99</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Tariq Mahmood, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093</b>							
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <b>[Signature]</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

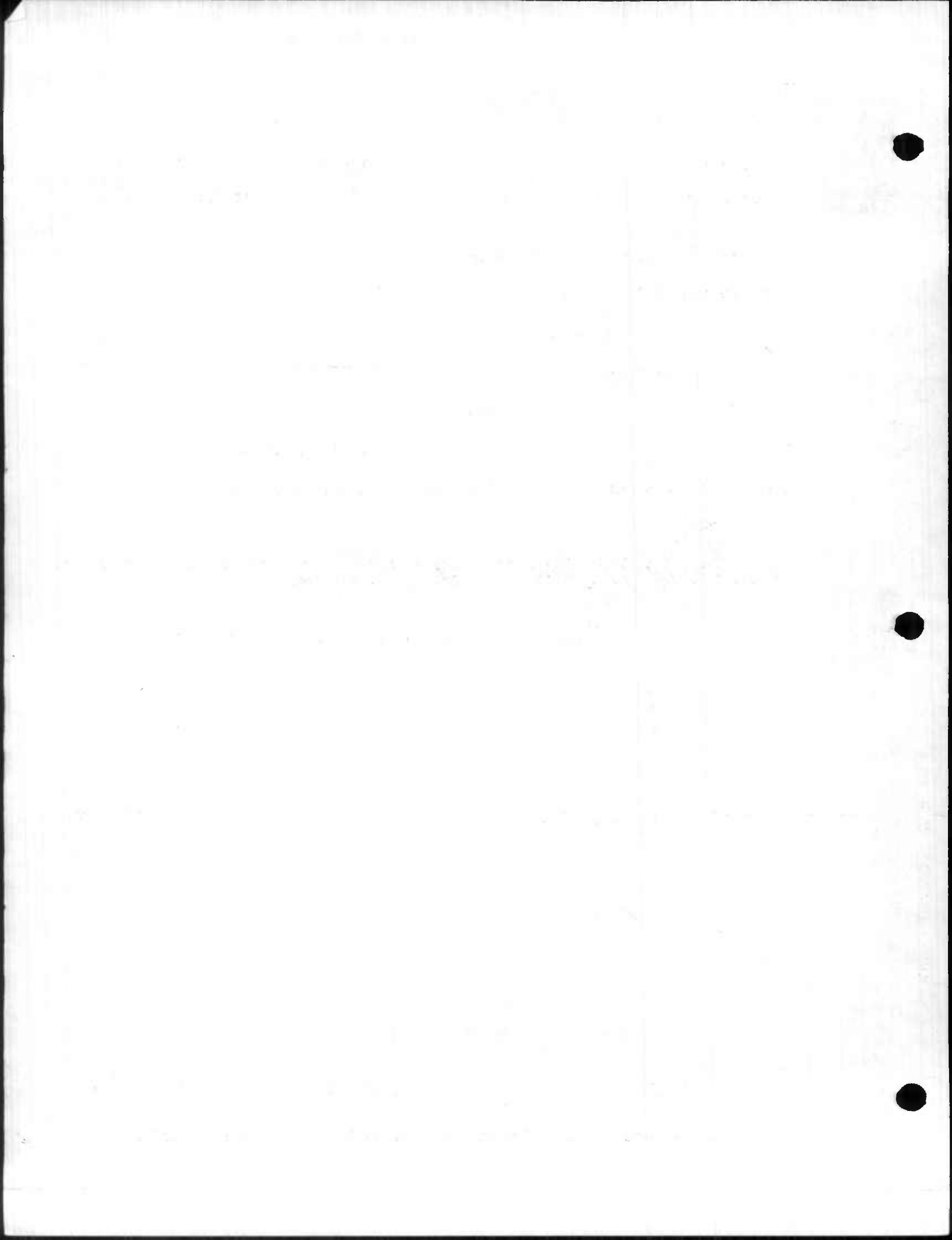
NAME: GLASCOE, RISA

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 16219

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

RUTH SMILEY CLIFFORD GORDON

2. Date of Death

May 14 1999

3. Time of Death

8:30PM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS / CARDINAL SHEHAN CTR.

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

5. Social Security Number

212-28-4561

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 28, 1916

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TIMONIUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

2300 DULANEY VALLEY ROAD

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

20+

18e. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

EDUCATOR / NURSERY SCHOOL

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

CHARLES SMILEY

18. Mother's Name (First, Middle, Maiden Surname)

ALICE BERRY

19e. Informant's Name/Relationship (Type, Print)

JOHN CLIFFORD, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1419 MT. CARMEL RD. PARKTON, MD. 21120

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

DEVID RIDGE CEMETERY

Date

MAY 19, 1999

20c. Location - City or Town, State

PIKESVILLE, MD.

21. Signature of Funeral Service Licensee

Chas. J. Evans

22. Name and Address of Facility

EVANS CHAPEL OF CHIMES  
2325 YORK RD. TIMONIUM, MD. 21093

23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary Artery Disease

Due to (or as a consequence of):

Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Long-term heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eddie Nakhuda

29c. License number

D 15504

29d. Date signed (Month, Day, Year)

5.14.99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Eddie Nakhuda, M.D. 2300 Dulane Valley Rd Timonium, Md 21093

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

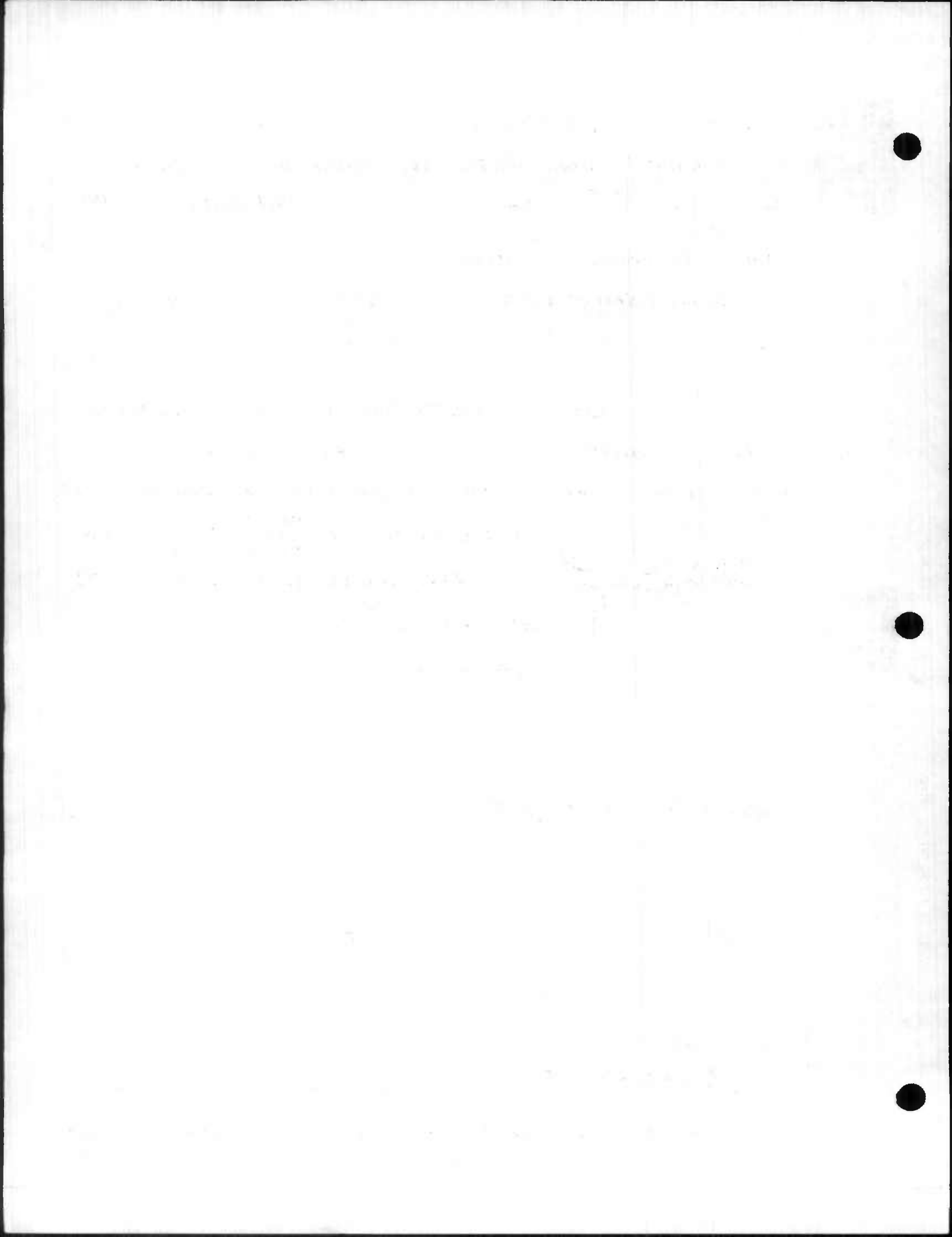
Division of Vital Records, P.O. Box 68760,

NAME: GORDON, RUTH

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16220

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Serena Harris</b>				2. Date of Death Month Day Year <b>May 14 99</b>		3. Time of Death <b>7:52P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214-90-1409</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>30</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 17, 1969</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1345 Kitmore Rd.</b>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>African American</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Ralph Leach</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Debra J. Harris</b>				
	19a. Informant's Name/Relationship (Type, Print) (Aunt) <b>Mrs. Marie Paul</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6016 Falkirk Rd. Balto. Md. 21239</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Udell Mem. Gardens</b>		20c. Location - City or Town, State <b>Dundalk, Md.</b>		21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		
	22. Name and Address of Facility <b>Joseph L. Russ Funeral Home</b>		22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Sepsis and Cellulitis</b> Due to (or as a consequence of): <b>Intravenous Drug Abuse</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Unknown</b> <b>Unknown</b>		22b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Dr. Manpreet Sanghari, M.D.</b>		29c. License number <b>P12676</b>		29d. Date signed (Month, Day, Year) <b>5/14/99.</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Manpreet Sanghari 90 Maryland General Hospital</b>	
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature <b>B. Sparks</b>							









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16222

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MATTIE S. HARRISON

2. Date of Death

MAY 18 1999

3. Time of Death

02:34AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-40-7471

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 26, 1914

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3113 RAVENWOOD AVENUE

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

JAMES MAYO

18. Mother's Name (First, Middle, Maiden Surname)

LUCINDA HENDRICKS

19a. Informant's Name/Relationship (Type, Print)

FAY V. HARRISON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

828 ABBOTT COURT BALTO, MD. 21202

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

MAY 22, 1999 BALTO, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Calvin B. Scruggs Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON STREET BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Marcus Brown M.D.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARCUS BROWN, M.D. 600 NORTH WOLFE STREET TOWER 110 BALTIMORE, MARYLAND 21287

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16223

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jessie Mae Harrell</i>					2. Date of Death Month <i>May</i> Day <i>18</i> Year <i>1999</i>		3. Time of Death <i>5pm</i>		
	4a. Facility Name (If not institution, give street and number) <i>4501 Mannasota Ave.</i>					4b. City, Town, or Location of Death <i>Balto.</i>		4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>231-44-7043</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>83</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>July 4, 1915</i>		9. Birthplace (State or Foreign Country) <i>North Carolina</i>	
	Usual Residence of Decedent									
10a. State <i>Md.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Balto.</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>4501 Mannasota Ave.</i>					10f. Zip Code <i>21206</i>		10g. Citizen of What Country? <i>U.S.A.</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Afro American</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11th</i> College (1-4 or 5+) <i>N/A</i>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housekeeper</i>			16b. Kind of Business/Industry <i>South Balto. General Hosp.</i>		
17. Father's Name (First, Middle, Last) <i>Charlie Grant</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Linnie</i>					
19a. Informant's Name/Relationship (Type, Print) <i>Dorothy DeCatur / Daughter</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4501 Mannasota Ave. Balto Md. 21206</i>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Balto. Cemetery</i>			Date <i>May 25 1999</i>		20c. Location - City or Town, State <i>Balto, Md.</i>		
21. Signature of Funeral Service Licensee <i>Calvin B. Scruggs</i>					22. Name and Address of Facility <i>Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213</i>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Probable Myocardial Infarction</i> Due to (or as a consequence of):  b. <i>Hypertension</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypothyroidism, Dementia, Left heel ulcer.</i>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>[Signature] M.D.</i>					29c. License number <i>D35082</i>		29d. Date signed (Month, Day, Year) <i>5/19/99</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>S. RAMESH 2323 ORLEANS ST. BALTIMORE, MD 21224</i>										
31. Date filed (Month, Day, Year) <i>MAY 20 1999</i>					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

*Joseph A. Murphy*

0000 0 3 YAM



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

39 16224

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Charles Hock				2. Date of Death Month Day Year May 15, 1999				3. Time of Death 12:45 PM		
	4a. Facility Name (If not institution, give street and number) Manor Care Rossville				4b. City, Town, or Location of Death Rossville				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 219-32-3683		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) 8/14/1936		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10e. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 316 Elinor Avenue				10f. Zip Code 21236				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales				16b. Kind of Business/Industry Electronics			
17. Father's Name (First, Middle, Last) George J. Hock				18. Mother's Name (First, Middle, Maiden Surname) Mary Ryan							
19e. Informant's Name/Relationship (Type, Print) Joan K. Hock/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Elinor Avenue Baltimore, Maryland 21236							
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		Date 5/19/99		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206							
23a. Pertinent illness, disease, or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End Stage Renal disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 year.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number D45475				29d. Date signed (Month, Day, Year) 5/19/99			
29b. Signature and title of certifier 				30. Name and address of person who completed cause of death (item 23e) (Type, Print) Mohammad Rahnema 17 Fontana Lane Baltimore, Maryland 21237							
31. Date filed (Month, Day, Year) MAY 20 1999				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEMS: #17, 18 PER F.H G771 5-20-1999 WR.

39 16225

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>BETTY HUMPHREY</b>		2. Date of Death Month <b>MAY</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>12:35 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital</b>			4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>
5. Social Security Number <b>291-16-5597</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>July 4, 1907</b>		9. Birthplace (State or Foreign Country) <b>France</b>			
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>2615 Royal Oak Ave</b>			10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>PAUL DUVEISE</b> <del>unknown</del>			18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE ROSEMARIE R. LANURE</b> <del>unknown</del>		
19a. Informant's Name/Relationship (Type, Print) <b>Ms. Hazel Robey Sister in law</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8200 Dogwood Rd Baltimore, Maryland 21244</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Good Shepherd Cemetery</b>		20c. Location - City or Town, State <b>Ellicott City, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. INCARCERATED VENTRAL HERNIA</b> Due to (or as a consequence of): <b>b. ABDOMINAL CARCINOMATOSIS</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D44505</b>		29d. Date signed (Month, Day, Year) <b>May 17, 1999</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>AT IMPERIAL JR. - NW Hc</b>					
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16226

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mildred Elaine Jordan</b>					2. Date of Death Month Day Year <b>May 12, 1999</b>		3. Time of Death <b>5:05 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>9962 Oak Lea Court</b>					4b. City, Town, or Location of Death <b>Ellicott City</b>		4c. County of Death <b>Howard</b>		
Funeral Director	5. Social Security Number <b>579-42-9789</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 22, 1913</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Ellicott City</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>9962 Oak Lea Court</b>				10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Credit Union Employee</b>			16b. Kind of Business/Industry <b>Credit Union</b>			
17. Father's Name (First, Middle, Last) <b>Julian Cockrell</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel McKenny</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Tom Jordan Son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9962 Oak Lea Court Ellicott City, Maryland 21042</b>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>05/15/99</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>moos35</b>					22. Name and Address of Facility <b>Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>CARCINOMA OF URINARY BLADDER</b>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <b>D18317</b>		29d. Date signed (Month, Day, Year) <b>5-13-99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Farrell, Bernard P. M.D. 11055 Little Patuxent Parkway Columbia, MD 21044</b>										
31. Date filed (Month, Day, Year) <b>MAY 20 1998</b>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

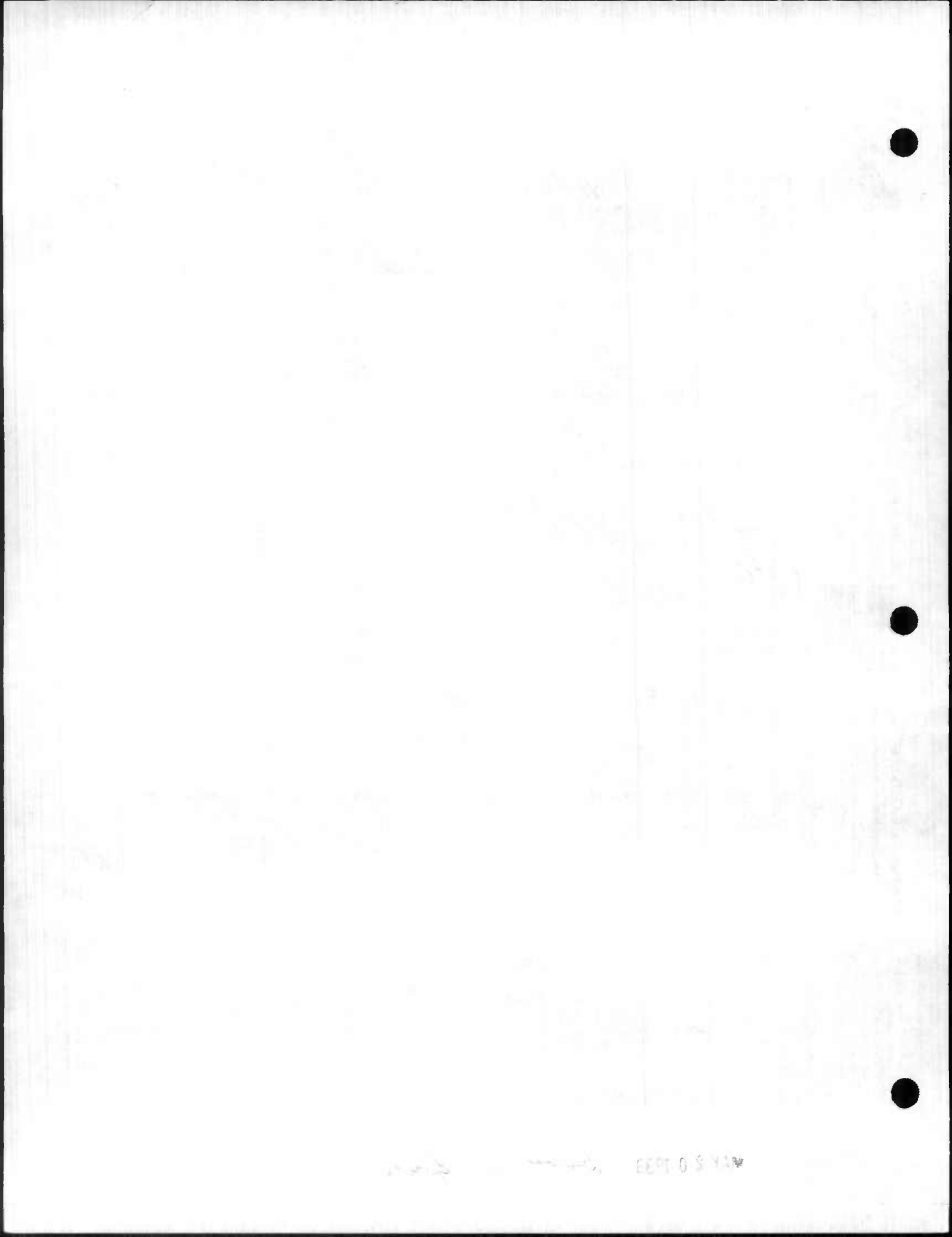
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



WMS 0 1033

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Sylvia Kandel

2. Date of Death

May 17<sup>th</sup> 1999 21:50

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

215-10-6006

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG 13 1915

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

PIKESVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7 SLADE AVE. APT. 418

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY

COLLER

18. Mother's Name (First, Middle, Maiden Surname)

MOLLYE

COHEN

19a. Informant's Name/Relationship (Type, Print)

DR. JEROME COLLIER / BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 POMONA EAST APT. 208 PIKESVILLE, MD. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CHIZUK AMUNO CONGREGATION

Date

5/19/99

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

Dexter H. Greene

22. Name and Address of Facility

SOL LEVINSON &amp; BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Cerebral Hemorrhage

Due to (or as a consequence of):

3 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Susan DeMeester

Surgical Resident RES-000

29c. License number

29d. Date signed (Month, Day, Year)

May 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan DeMeester, MD

Sinai Hospital, Baltimore

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Spindel

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16228

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Kuzyk</b>				2. Date of Death Month Day Year <b>May 17 1999</b>		3. Time of Death <b>9:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3901 Balfern Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>219-16-8324</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 8 1925</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Md.</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>3901 Balfern Avenue</b>				10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S. of America</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>			16b. Kind of Business/Industry <b>Manufacturing</b>	
17. Father's Name (First, Middle, Last) <b>Peter Rostkowski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Sierak</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Antoinette Gryken (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1007 South East Ave. Baltimore, Md. 21224</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Stanislaus</b>		Date <b>May 21</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>
21. Signature of Funeral Service Licensee <i>Mark A. Popovich</i>				22. Name and Address of Facility <b>W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Probable acute Myocardial Infarction</b> <b>Coronary Artery Insufficiency</b> <b>Arterio Sclerotic Cardiovascular Disease Many years</b>								Approximate Interval Between Onset and Death <b>Hours</b> <b>Days</b> <b>Years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Malabsorption.</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Mark A. Popovich</i>				29c. License number <b>D17085</b>		29d. Date signed (Month, Day, Year) <b>May 18, 1999</b>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>A. F. Nour M.D. 1576 Merritt Blvd. Dundalk, Maryland 21222</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <i>Debra B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: #5 PER INFORMANT G771 State of Maryland / Department of Health and Mental Hygiene  
ITEM#23 PART-1 & PART II PER PHYSN. G771 5-20-99

Reg. No.

99 16229

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Gertrude Lee</u>		2. Date of Death Month <u>April</u> , Day <u>24</u> , Year <u>1999</u>		3. Time of Death <u>3:50 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Geriatric Center</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>215-16-0698</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>95</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>Aug 20, 1903</u>		9. Birthplace (State or Foreign Country) <u>VA</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>BALTO</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <u>4119 Woodhaven Ave</u>			10f. Zip Code <u>21216</u>		10g. Citizen of What Country? <u>U.S.A.</u>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4th</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housewife</u>		16b. Kind of Business/Industry <u>domestic</u>	
17. Father's Name (First, Middle, Last) <u>Edward Nicholas</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>ANNIE HARRIS</u>			
19a. Informant's Name/Relationship (Type, Print) <u>RAYMOND LEE</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4119 Woodhaven Ave Balto, Md 21216</u>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Jersulum Bapt CH CEM</u>		20c. Location - City or Town, State <u>4-30-99 Dillwyn VA</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Betts Funeral Home</u> <u>1129 N. Caroline St Balto, Md 21213</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) e. <u>sepsis</u> Due to (or as a consequence of): <u>MALNUTRITION</u>					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. <u>malnutrition</u> Due to (or as a consequence of): <u>NECROTIC SACRAL PRESSURE ULCER</u>					
g. <u>neurotic sacral pressure ulcer</u> Due to (or as a consequence of): <u>NECROTIC SACRAL PRESSURE ULCER</u>					
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <u>① femur fracture</u> <u>anemia</u> <u>osteoporosis</u>					
23b. Did tobacco use contribute to the causa of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D0051156</u>		29d. Date signed (Month, Day, Year) <u>4/24/99</u>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>FAINA V. CAPAN, M.D. 5305 BAYVIEW Circle, JHGG, Balto. 21224</u>					
31. Date filed (Month, Day, Year) <u>MAY 20 1999</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16230

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>ROSE R MEDONICK</i>				2. Date of Death Month <i>5</i> Day <i>17</i> Year <i>99</i>		3. Time of Death <i>6:00pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Montgomery General Hospital</i>				4b. City, Town, or Location of Death <b>OLNEY</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <i>089-09-1873</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>88</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>11/16/10</i>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>3701 INTERNATIONAL DRIVE</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>ABRAHAM RODIN</b>				18. Mother's Name (First, Middle, Maiden Sumama) <b>THERESA STERNBERG</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ABBY M. ZIZMOR/ DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18530 KILT TERRACE OLNEY, MD. 20832</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SHAAREI ZION CONGREGATION</b>		20c. Location - City or Town, State <b>5/19/99 BALTIMORE MD.</b>		
21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>pneumonia</i> Dua to (or as a consequence of):  b. Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Deep vein Thrombosis</i> <i>Peripheral Vascular Disease</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>053864</i>		29d. Date signed (Month, Day, Year) <i>5/18/99</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Richard A. Silva, Montgomery Co General</i>								
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

January 20

1940

20

10-12-40

5 p.m.

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100 10-5 YAM



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Don

McGhay

2. Date of Death  
Month Day Year

May

15

1999

3. Time of Death

8:37 pm

4e. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

5. Social Security Number

239-52-2862

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 11, 1937

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

413 Rockfleet Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Durward McGhay

18. Mother's Name (First, Middle, Maiden Surname)

Edmee Schmitz

19a. Informant's Name/Relationship (Type, Print)

Mrs. Ellen McGhay

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 Rockfleet Road Timonium, Maryland 21093

20e. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

5/19/99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

*Michael Ruck*

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Road Towson, Maryland 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sepsis

e. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. pneumonia  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24e. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*William T. B. M.D. Pathologist*

29c. License number

D0035405

29d. Date signed (Month, Day, Year)

5/17/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

5401 Old Court Rd Randallstown MD 21133

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

*B. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MD 21204

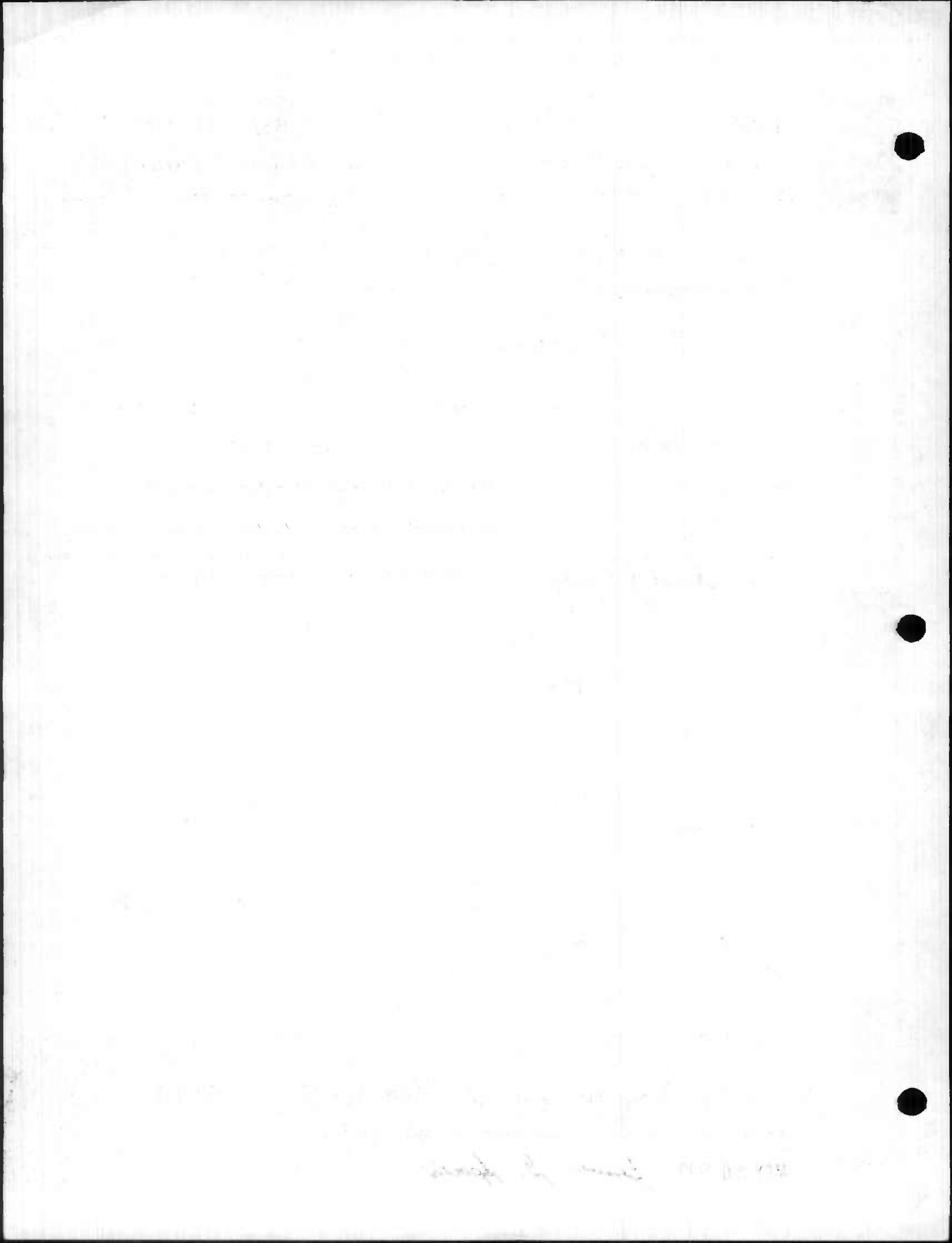
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16232

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Joseph Manzo, Jr.				2. Date of Death Month Day Year May 18, 1999				3. Time of Death 1:50 P.M.		
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number 219-56-6929		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 1, 1951		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Towson				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 8206 Boman Court				10f. Zip Code 21204		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Business Owner				16b. Kind of Business/Industry Moving Company			
17. Father's Name (First, Middle, Last) Daniel J. Manzo, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Mary E. Noppinger					
19a. Informant's Name/Relationship (Type, Print) Mrs. June D. Manzo/Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8206 Boman Court Towson, Maryland 21204					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 5/22/99		20c. Location - City or Town, State Baltimore, Maryland			
21. Signature of Funeral Service Licensee Michael Suckor				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month/Day/Year) 5/18/99		28b. Time of Injury 1311 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver in auto accident	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street				28f. Location (Street and Number or Rural Route Number, City or Town, State) I-695 at Exit 26; 21093							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier J. A. B. [Signature]	
29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) May 19, 1999							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. A. B. [Signature] 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) MAY 20 1999				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

*Handwritten signature*

RECEIVED YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

ITEM#26 PER PHYNS. G771 5-20-99 J.A.

Reg. No.

99 16233

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL CHARLES MITZEL, SR.

2. Date of Death

May 4, 1999

3. Time of Death

7:30 a.m.

4a. Facility Name (If not institution, give street and number)

1311 Sweet Briar Lane

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-18-1872

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 5, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1311 Sweet Briar Lane

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+ years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Chief Warrant Officer

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Charles Warren Mitzel

18. Mother's Name (First, Middle, Maiden Surname)

Julia Allen

19a. Informant's Name/Relationship (Type, Print)

Paul C. Mitzel, JR. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1311 Sweet Briar Lane, Bel Air, MD. 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

5/7/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

ischemic cardiomyopathy

Due to (or as a consequence of):

b.

coronary artery disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Were autopsy findings performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

H0052780

29d. Date signed (Month, Day, Year)

May 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL SEGAL 4940 BETHAM EASTERN AVENUE BALTIMORE, MARYLAND 21224

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

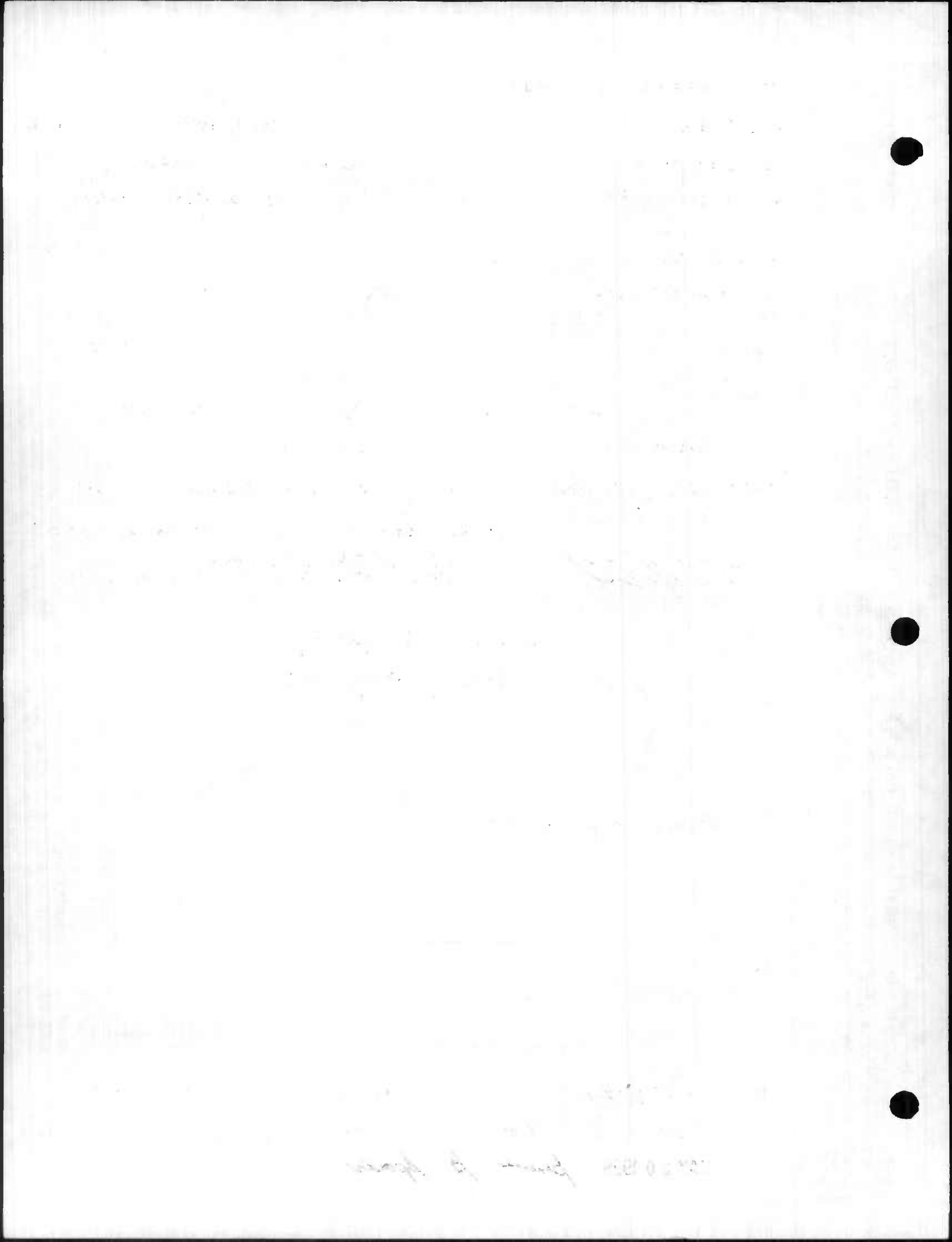
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16234

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANK WHITNER MARTIN, JR.</b>				2. Date of Death Month <b>MAY</b> Day <b>13</b> Year <b>1999</b>		3. Time of Death <b>1435 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>228-68-3339</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 5, 1948</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>					
To Be Completed by Funeral Director	10a. State <b>VA</b>		10b. County <b>Fairfax</b>		10c. City, Town or Location <b>Great Falls</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>426 Springvale Rd.</b>				10f. Zip Code <b>22066</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Repair Telecommunications</b>		16b. Kind of Business/Industry <b>Communications</b>			
	17. Father's Name (First, Middle, Last) <b>Frank Whitner Martin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma J. Jackson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Alah Kay Martin</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>426 Springvale Rd., Great Falls, VA 22066</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>5/15/99 Alexandria, VA</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Green Funeral Home, 721 Elden St., Herndon, VA 20170</b>					
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Multiple Myeloma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>5-13-99</b>		28b. Time of Injury <b>13:15 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred <b>DRIVEN OFF CAR HIT GUARDRAIL</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>E.B. RT 50 ANNAPOLIS CO. MD</b>			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>MAY 14, 1999</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>MARYSANTA KOWAL 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM FREDRICK NEUGEBAUER				2. Date of Death Month MAY Day 14 Year 1999		3. Time of Death 10:06 PM			
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number 060-01-3821		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 21, 1915	9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Howard		10c. City, Town or Location Laurel			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 7929 Helmart Drive				10f. Zip Code 20723		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Adjutant General			16b. Kind of Business/Industry U. S. Army		
	17. Father's Name (First, Middle, Last) William Neugebauer				18. Mother's Name (First, Middle, Maiden Surname) Anna Thoden					
	19a. Informant's Name/Relationship (Type, Print) Katherine J. Neugebauer - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7929 Helmart Drive, Laurel, Md. 20723					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		20c. Location - City or Town, State Arlington, Virginia			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., ElkrIDGE, Md. 21075					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CORONARY ARTERY DISEASE Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D-19545		
29d. Data signed (Month, Day, Year) 5/17/99										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LESLIE HARDWARE, MD				NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600						
31. Date filed (Month, Day, Year) MAY 20 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMENDED #5 &amp; #6 PER 7FH G771/5/20/99-AH

99 16236

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEE DUNIE PHILLIPS

2. Date of Death

MAY 14 1999 0249 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SINA HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220-14-1904

6. Sex

M XX F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 3, 1904

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1X Yes 2X No

10e. Street and Number

6018 CROSS COUNTRY BLVD.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1X Never Married 2X Married  
3X Widowed 4X Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2X No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1X Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 YRS.

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

CLOTHING

17. Father's Name (First, Middle, Last)

HARRIS

18. Mother's Name (First, Middle, Maiden Surname)

DUNIE

MAUDE

LEVENWALD

19a. Informant's Name/Relationship (Type, Print)

MRS. BETTY FEINBERG (DAUG)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6018 CROSS COUNTRY BLVD. BALTO. MD 21215

20a. Method of Disposition

1X Burial 2X Cremation 3X Removal from State  
4X Donation 5X Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANSHE EMUNAH(AITZ CHAIM) 517-99

Date

20c. Location - City or Town, State

BALTO. MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON BROS., INC.  
8900 REISTERSTOWN RD. BALTO. MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

48 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1X Yes 2X No 3X Probably 4X Unknown

24a. Was an autopsy performed?

1X Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1X Yes 2X No

25. Was case referred to medical examiner?  
1X Yes 2X No

Hospital:

1X Inpatient

2X ER/Outpatient

3X DOA

Other:

4X Nursing Home

5X Residence

6X Other (Specify)

27. Manner of Death

1X Natural 5X Pending Investigation  
2X Accident 6X Could not be determined  
3X Suicide  
4X Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1X Yes 2X No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRAIG SINGER 2401 W. BELVEDERE AVE. BALTIMORE MD

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

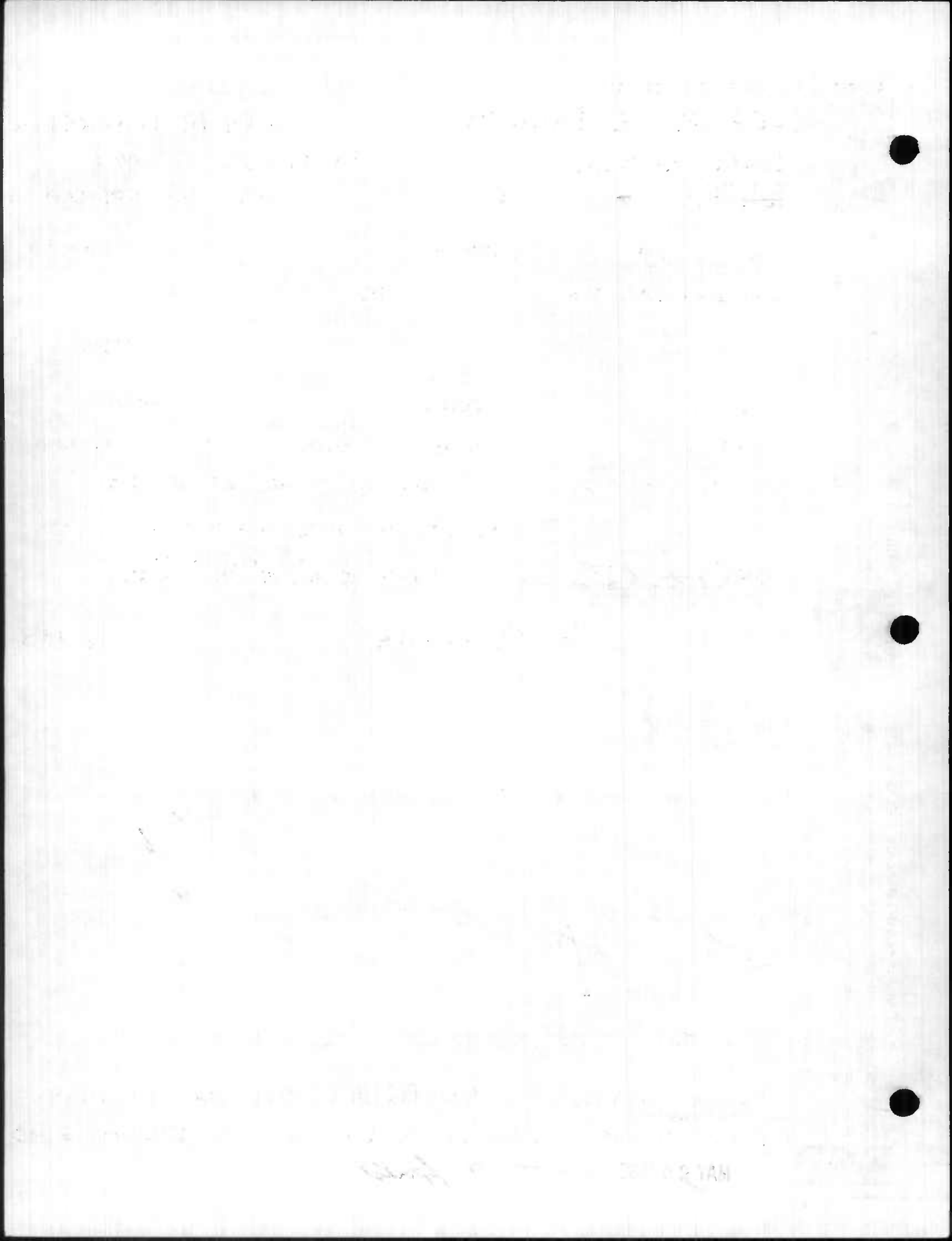
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16237

ITEMS: #10D, 19A-B PER F.H. G771 5-20-99 WR.

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Carlin Peyton

2. Date of Death

04 13 99

3. Time of Death  
5:40 Am

4a. Facility Name (If not institution, give street and number)

Dulaney Towson Health Care Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

549-24-6772

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9/27/10

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

111 West Street

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Purchasing Agent

16b. Kind of Business/Industry

Building

Maintenance

17. Father's Name (First, Middle, Last)

Courtland Frances Peyton

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Mae Johnson

19a. Informant's Name/Relationship (Type, Print)

KEN LABOWITZ, ATTORNEY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 324 ALEXANDRIA, VA 22313

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan

Date

4/16/99 Alexandria, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pearson Funeral Home

472 N Washington St Falls Church, VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. CEREBROVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

047945

29d. Date signed (Month, Day, Year)

April 16 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harris Aleem 3007 E Northern Parkway Baltimore MD 21214

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

State  
RegistrarCarlin Peyton  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

HELEN

PENN

2. Date of Death

May 11, 1999

3. Time of Death

1:20am

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-68-0147

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

APR 30 1956

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5 S CULVER STREET

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATOR ASSISTANT

16b. Kind of Business/Industry

BALTIMORE CITY  
PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

GEORGE W. TRENT

18. Mother's Name (First, Middle, Maiden Surname)

MATTIE MILLER

19a. Informant's Name/Relationship (Type, Print)

Tia L. Barrett/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2807 Prestman St., Baltimore, Maryland 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

5-15-99

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA  
1206 W NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RENAL FAILURE

Due to (or as a consequence of):

3 YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

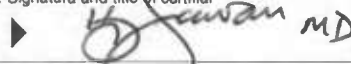
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. K. SAWAN

600

N. WOLFE STREET

BALTIMORE

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

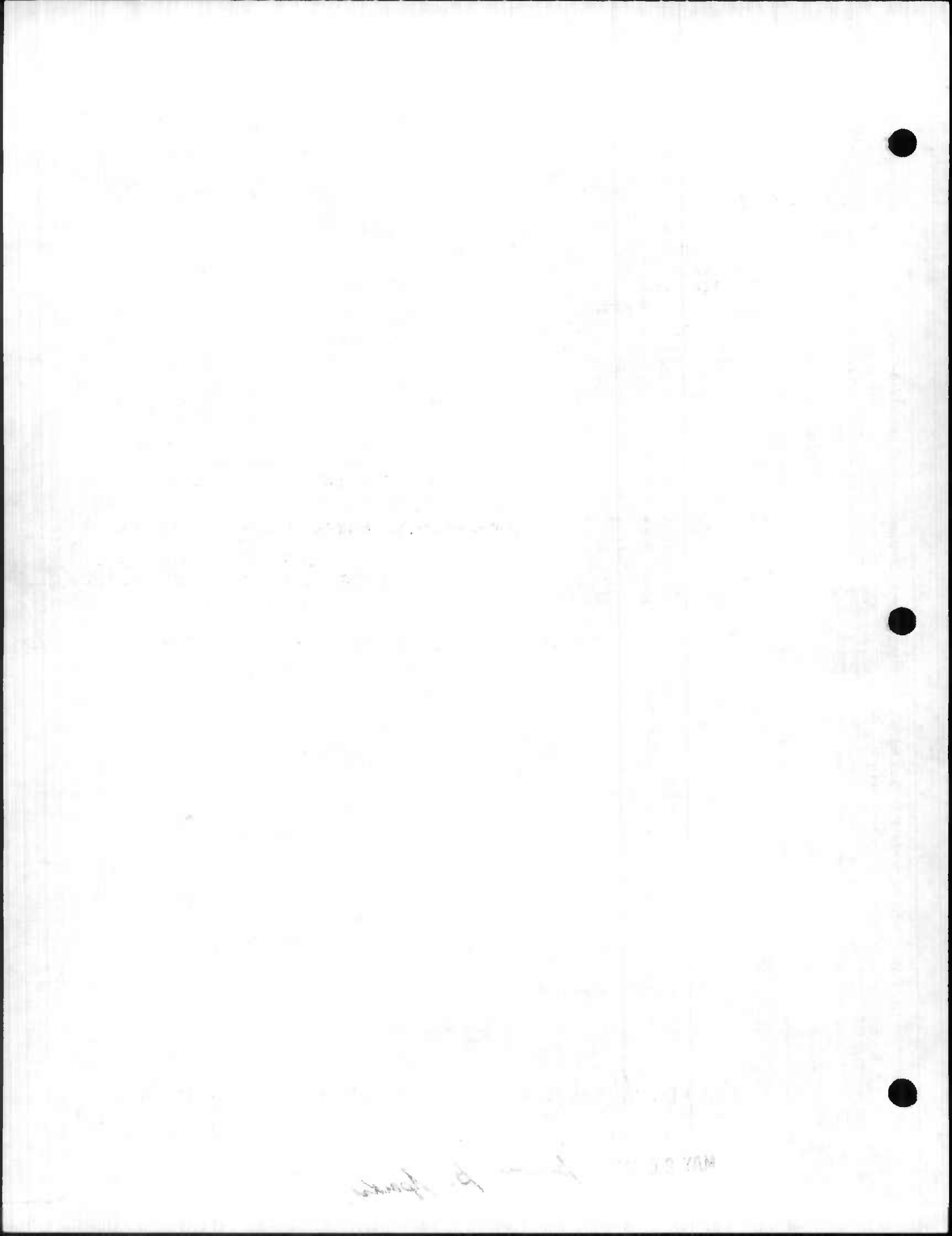
Reg. No.

99 16239

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VERA GISELLA REICHER</b>				2. Date of Death Month Day Year <b>May 17 1999</b>		3. Time of Death <b>3:15 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>7904 IVY LANE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>487-05-8005</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 11 1913</b>	9. Birthplace (State or Foreign Country) <b>AUSTRIA</b>
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>	
10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7904 IVY LANE</b>		10f. Zip Code <b>21208</b>
10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COSMETOLOGIST</b>		16b. Kind of Business/Industry <b>COSMOTOLOGY</b>
17. Father's Name (First, Middle, Last) <b>BERNARD SEIDEN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>JEANETTE (UNKNOWN)</b>		19a. Informant's Name/Relationship (Type, Print) <b>JUDITH LEITTESS/ DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7904 IVY LANE BALTIMORE, MD. 21208</b>
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>JUDEAN MEMORIAL GARDENS</b>		20c. Location - City or Town, State <b>5/19/99 OLNEY, MD.</b>		
21. Signature of Funeral Service Licensee <i>Jay May Lewis</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC.</b> <b>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Chronic myelogenous leukemia in blast phase 6 mo</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>6 mo</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Carol B Miller</i>		29c. License number <b>D35254</b>		
29d. Date signed (Month, Day, Year) <b>5-18-99</b>				29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Carol B Miller MD Room 167 Johns Hopkins Onc Ctr 600 N Wolfe St Baltimore MD 21287</b>				
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16240

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Claude Rucker</b>				2. Date of Death Month Day Year <b>May 10 1999</b>		3. Time of Death <b>12:42 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mercy Medical center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-09-4022</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5-2-19</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10. Usual Residence of Decedent 10a. State <b>MD.</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>BALTIMORE</b> 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		11. Street and Number <b>1842 N. WOLFE ST.</b>		12. Zip Code <b>21213</b>	
13. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		14. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		15. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		16. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
17. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>-10-</b> College (1-4 or 5+) <b>-0-</b>		18. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINE OPERATOR</b>		19. Kind of Business/Industry <b>WAREHOUSE</b>		20. Father's Name (First, Middle, Last) <b>UNKNOWN</b>		
21. Mother's Name (First, Middle, Maiden Summa) <b>UNKNOWN</b>		22. Informant's Name/Relationship (Type, Print) <b>DAVID FIELDS (NEPHEW)</b>		23. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>509-11 EASTVIEW TERRACE ABINGDON, MARYLAND 21009</b>		24. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
25. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>		26. Date <b>5-24-99</b>		27. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>		28. Signature of Funeral Service Licensee <b>[Signature] CFSP</b>		
29. Name and Address of Facility <b>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</b>		30. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis</b> Due to (or as a consequence of): <b>b. Pneumonia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Renal Failure</b> <b>Aplastic Anemia</b>		31. Approximate Interval Between Onset and Death <b>12 days</b> <b>12 days</b>		32. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b> <b>Aplastic Anemia</b>		
33. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		34. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		35. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		36. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
37. Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		38. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		39. 25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		40. 26. Place of Death (Check only one)		
41. 27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		42. 28a. Date of Injury (Month, Day, Year) <b>May 10 1999</b>		43. 28b. Time of Injury <b>M</b>		44. 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
45. 28d. Describe how injury occurred		46. 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		47. 28f. Location (Street and Number or Rural Route Number, City or Town, State)		48. 29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
49. 29b. Signature and title of certifier <b>Vijay Pethkar M.D.</b>		50. 29c. License number <b>D50853</b>		51. 29d. Date signed (Month, Day, Year) <b>May 10, 1999</b>		52. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mercy Medical center 301 St. Paul Place Baltimore MD 21202</b>		
53. 31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		54. 32. Registrar's Signature <b>[Signature]</b>		55. 31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		56. 32. Registrar's Signature <b>[Signature]</b>		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

March 20, 1900

Dear Mr. [illegible]

I have just received your letter of the 17th inst. and am glad to hear from you. I am well and hope this finds you the same. I have been thinking of you very much lately and wondering how you are getting on. I hope you are happy and successful in all your undertakings.

I have not much news to write you at present. Everything is going on as usual here. I am still working hard and trying to improve myself in every way possible. I hope to hear from you again soon.

I am, dear Mr. [illegible], very truly yours,  
[illegible signature]

Yours very truly,  
[illegible signature]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16241

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANK RIDRIGS</b>				2. Date of Death Month <b>MAY</b> Day <b>18</b> Year <b>1999</b>				3. Time of Death <b>7:30P</b>	
	4a. Facility Name (If not institution, give street and number) <b>EAST POINT Rehab</b>				4b. City, Town, or Location of Death <b>BAI.TO.</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-72-6214</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>06-25-25</b>		9. Birthplace (State or Foreign Country) <b>BAI.TO. MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>606 CATHEDRAL ST</b>				10f. Zip Code <b>21201</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MERCHANT SEAMAN</b>				16b. Kind of Business/Industry <b>MERCHANT SEAMAN</b>		
17. Father's Name (First, Middle, Last) <b>ANTONIO RIDRIGS</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>LILLIAN RIDRIGS</b>					
19a. Informant's Name/Relationship (Type, Print) <b>GEORGE RANDOLPH (SON)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>223 E. BIDDLE ST, BALTO. MD 21201</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>			20c. Location - City or Town, State <b>5-24-99 RANDALLSTOWN, MD</b>				
21. Signature of Funeral Service Licensee <i>Willie E. Hight</i>					22. Name and Address of Facility <b>LEROY O DYETT &amp; SON FUNERAL HOME</b> <b>4600 LIBERTY HIGHTS AVE, BALTO. MD 21207</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>PROSTATE CANCER WITH BONE METASTASES</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>James F. Davis MD</i>				29c. License number <b>D38033</b>				29d. Date signed (Month, Day, Year) <b>5/20/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>261 S. HIGHLAND AVE BALTIMORE, MD 21224</b>										
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature <i>James B. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>MILDRED SNYDER</b>		2. Date of Death Month <b>May</b> Day <b>17th</b> Year <b>1999</b>		3. Time of Death <b>5 25 AM</b>
4a. Facility Name (If not institution, give street and number) <b>LEVINDALE NURSING HOME</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>213-01-8526</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>NOV. 8, 1916</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>15 COBBLESTONE COURT #2D</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BOOKKEEPER</b>		16b. Kind of Business/Industry <b>REAL ESTATE</b>		
17. Father's Name (First, Middle, Last) <b>ELLIS PRESS</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>REBECCA TAYLOR</b>		
19a. Informant's Name/Relationship (Type, Print) <b>LESLIE CIMINO / DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>708 SILVER CREEK ROAD - BALTIMORE, MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN CEMETERY</b>		20c. Location - City or Town, State <b>5/19/99 WOODLAWN, MD</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>acute cardio-pulmonary arrest</u> Due to (or as a consequence of):  b. <u>neuropathy (progressive)</u> Due to (or as a consequence of):  c. <u>monoclonal gammopathy</u> Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <u>depression</u> <u>dysphagia</u> <u>UTI urinary tract infections</u> <u>anxiety</u> <u>slight gastrostomy tube</u> <u>constipation</u> <u>osteoporosis</u> <u>neurogenic bladder</u> <u>1/2 suprapubic Foley</u>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Consul M. Wynn</b>		
29c. License number <b>D:44907</b>		29d. Date signed (Month, Day, Year) <b>May 17th 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2434 W. Belvedere Ave Balto, MD 21215</b>				
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 		

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Snyder, Mildred

Handwritten signature and text: *Handwritten signature* SET D 2 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16243

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joyce L. Stone				2. Date of Death Month Day Year May 18 1999				3. Time of Death 5:00 pm	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-34-4266		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 15, 1937		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Harford		10c. City, Town or Location Bel Air				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 907 Millstone Court				10f. Zip Code 21014				10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker				16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Calvin Richardson				18. Mother's Name (First, Middle, Maiden Surname) Edna Joyce						
19a. Informant's Name/Relationship (Type, Print) Mr. George Stone / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Millstone Court Bel Air, Maryland 21014						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gds.		20c. Date 5/22/99		20d. Location - City or Town, State Timonium, Maryland		
21. Signature of Funeral Service Licensee Michael Ruff				22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. Stage IV Endometrial Carcinoma Due to (or as a consequence of): b. Cardiopulmonary arrest Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate interval Between Onset and Death one year 30 minutes										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how Injury occurred						
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Roberto Andrade, MD				29c. License number AT2438996				29d. Date signed (Month, Day, Year) May 18, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roberto Andrade, MD, UNION MEMORIAL HOSPITAL, BALTIMORE, MD										
31. Date filed (Month, Day, Year) MAY 20 1999				32. Registrar's Signature Benjamin B. Sparks						

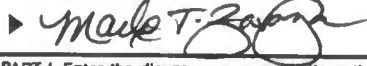


*Handwritten signature*

0821 0 2 YAM

99 16244

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES E. SPENCE, SR.</b>				2. DATE OF DEATH MONTH <b>May</b> DAY <b>19</b> YEAR <b>1999</b>		3. TIME OF DEATH <b>7:35 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>077-09-3390</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>98</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 21, 1901</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Multi-Medical Ctr.-Genesis Eldercare</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		8c. COUNTY OF DEATH <b>Baltimore</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Fallston</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1314 Old Fallston Road</b>	
10f. ZIP CODE <b>21047</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electrical Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Power Plant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>W. A. Spence</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith Dow</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles E. Spence, Jr. (Son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6923 Satinleaf Rd., North #104, Naples, Fla. 34109</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b> <b>5/20/99</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schmunek Funeral Home of Bel Air, Inc.</b> <b>610 W. MacPhail Road, Bel Air, MD. 21014</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Failure to thrive</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Unspecified left Lung MASS</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation, Dementia</b> <b>ASHD, previous myocardial infarction</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D17118</b>		29d. DATE SIGNED (Month, Day, Year) <b>5/19/99</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul Schwartz M.D. 115 E. Melrose Ave 21212</b>							
31. DATE FILED (Month, Day, Year) <b>MAY 20 1999</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16245

ITEM#19A,19B PER F.H. G771 5-20-99 J.A.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLARA M. SMITH</b>				2. Date of Death Month Day Year <b>MAY 17 1999</b>		3. Time of Death <b>1700</b>
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>
Funeral Director	5. Social Security Number <b>213-34-0644</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 19, 1931</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>CATONSVILLE</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>6348 FREDERICK ROAD</b>			10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSE</b>		16b. Kind of Business/Industry <b>MEDICAL</b>		
	17. Father's Name (First, Middle, Last) <b>HERBERT SUTTON</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>VADA GUMM</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>ELIZABETH BIDINOTTO, DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 477, FRISCO, COLORADO 80043</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SACRED HEART OF MARY</b>		Date <b>5/21/99</b>	20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Pneumonia</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>10 days</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 			29c. License number <b>043323</b>		29d. Date signed (Month, Day, Year) <b>MAY 18, 1999</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Aheda Ali Khan, M.D. 5755 CEDAR LANE, COLUMBIA, MARYLAND 21044</b>							
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16246

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FANNYE TARLOW</b>				2. Date of Death Month <b>MAY</b> Day <b>17</b> Year <b>1999</b>		3. Time of Death <b>9PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>PIKESVILLE NURSING HOME</b>				4b. City, Town, or Location of Death <b>PIKESVILLE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>212-26-4072</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>96</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APRIL 27 1903</b>		
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>						
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>3809 GLEN AVENUE</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER</b>		16b. Kind of Business/Industry <b>TARLOW FUR COMPANY</b>				
	17. Father's Name (First, Middle, Last) <b>JOSEPH TOPOR</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DAVID TARLOW/ SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>306 OLD CROSSING DRIVE BALTIMORE, MD. 21208</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SHAAREI ZION CONGREGATION</b>		20c. Location - City or Town, State <b>BALTIMORE, MD.</b>		20d. Date <b>5/19/99</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of): <b>Dehydration</b> Due to (or as a consequence of): <b>Drugs and medical treatment</b> Due to (or as a consequence of): <b>Chronic obstructive pulmonary disease</b>								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D 30339</b>		29d. Date signed (Month, Day, Year) <b>5/18/99</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Milan WINTER, MD 4000 Old Court Rd; BALTIMORE, MD 21208</b>	
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 							

Handwritten signature and date: MAY 30 1969

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

IYEM#24a PER DCTR. G771 5-20-99 J.A.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LESLIE

2. Date of Death

MAY 1, 1999

Day Year

3. Time of Death

5:15pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

212-26-2923

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 21, 1911

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5220 York Road, #4G

10f. Zip Code

21212

10g. Citizen of What Country?

unknown

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

if Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify:

unknown

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HYPOXIA

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

c. CAD

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 days

&gt; 1 year

&gt; 1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

P-11389

29d. Date signed (Month, Day, Year)

MAY, 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GILBERT ZOGHBI, 6935 DONACHIE RD #G, BALTIMORE, MD

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Sparks

21239

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

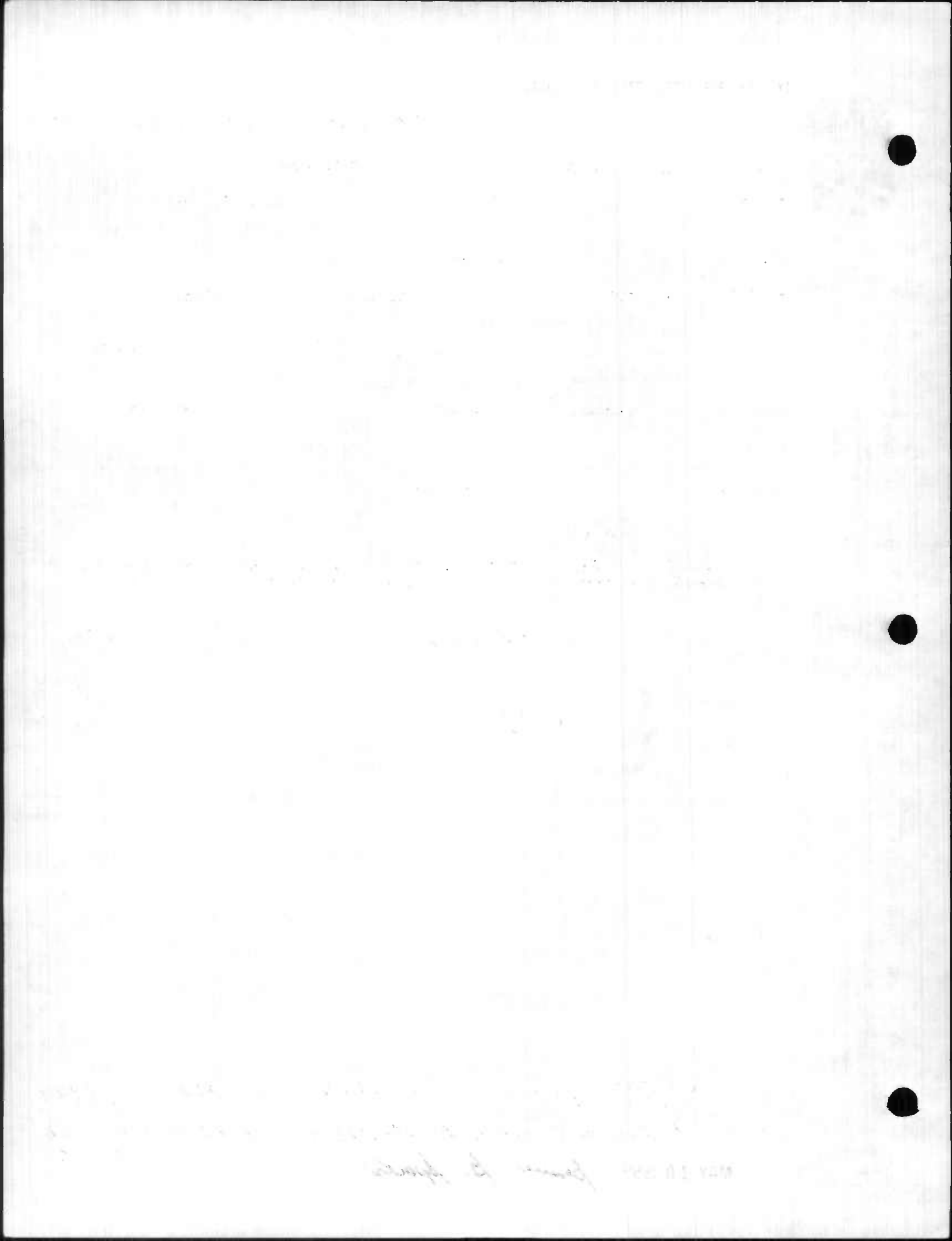
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16248

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PATRICE R WALKER</b>				2. Date of Death Month <b>5</b> Day <b>16</b> Year <b>99</b>		3. Time of Death <b>2:19 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-84-5536</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>8/2/60</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>1040 EDMONDSON AVENUE</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NEVER WORKED</b>		16b. Kind of Business/Industry <b>NIA</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>LEROY WALKER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ELRENE MORGAN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>BRENDA WALKER (STEP-MOTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5716 WINNER AVENUE, BALTIMORE, MD. 21245</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>VOSHELL GARDENS CEMETERY</b>		20c. Date <b>05-21-99</b>		20d. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. AORTIC RING ABSCESS</b> Due to (or as a consequence of):  <b>b. BACTERIAL ENDOCARDITIS</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HIV</b>  <b>END-STAGE RENAL DISEASE</b>							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
State Registrar	29a. Signature and title of certifier 				29c. License number <b>P11771</b>		29d. Date signed (Month, Day, Year) <b>5/16/99</b>	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>THOMAS E. HASLEN 22 S. GREENIE ST. BALTIMORE, MD 21201</b>							
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

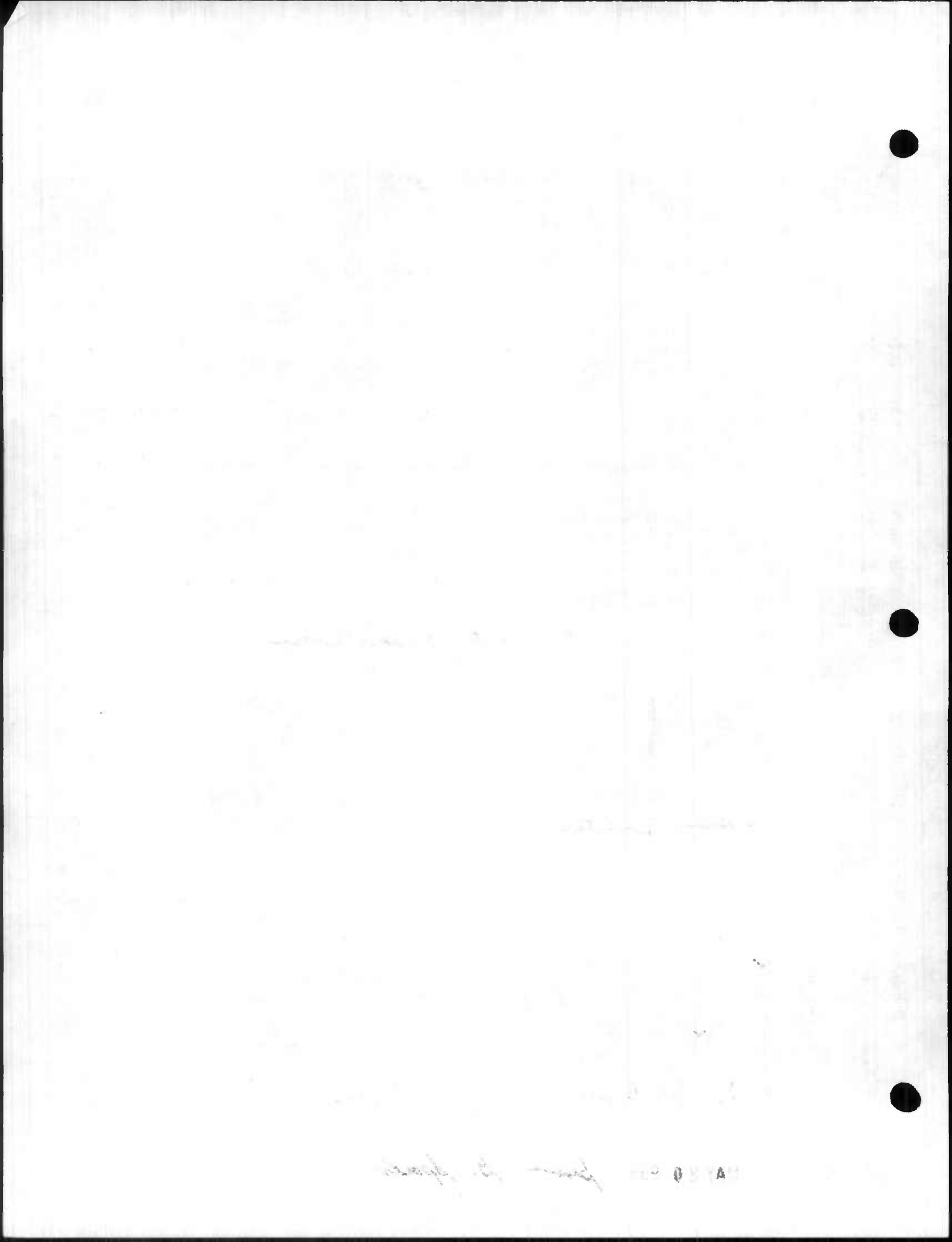
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16249

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELISABETH KIRK WELLER					2. Date of Death Month Day Year May 17, 1999			3. Time of Death 6:00 PM	
	4a. Facility Name (If not institution, give street and number) Wesley Home					4b. City, Town, or Location of Death Baltimore City			4c. County of Death N/A	
Funeral Director	5. Social Security Number 219-44-9910		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 2, 1903		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2211 W. Rogers Avenue				10f. Zip Code 21209		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Residence			
	17. Father's Name (First, Middle, Last) Charles Edgar Kirk					18. Mother's Name (First, Middle, Maiden Surname) Anna Miles				
	19a. Informant's Name/Relationship (Type, Print) Anna W. Dahl, (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 W. University Pkwy, #113, Baltimore, MD 21210				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 5/20/99			
	21. Signature of Funeral Service Licensee Martin D. Lawson					22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Vascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, Dehydration.									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier R. Liberto, M.D.					29c. License number D21464			29d. Date signed (Month, Day, Year) 5/19/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Liberto, M.D., 3805 Bank Street, Baltimore, MD 21224										
31. Date filed (Month, Day, Year) MAY 20 1999		32. Registrar's Signature B. Sparks								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16250

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN W. WHITE</b>				2. Date of Death Month <b>MAY</b> Day <b>14</b> Year <b>1999</b>				3. Time of Death <b>2:00AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>228-18-1417</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 31, 1923</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2735 N. ROSEDALE STREET</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1948-49</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BAGGER</b>				16b. Kind of Business/Industry <b>CALVERT DISTILLERY</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JOHN ALBERT WHITE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GENEVA DAVIS</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>LINDA WHITE/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2735 N. ROSEDALE STREET, BALTIMORE, MD. 21216</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST V.A.</b>		20c. Location - City or Town, State <b>5/18/99 REISTERSTOWN, MD.</b>					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Metastatic colon Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>16 MONTHS</b>								Approximate Interval Between Onset and Death <b>16 MONTHS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>M. Purcell, Staff Physician</b>		29c. License number <b>019714</b>		29d. Date signed (Month, Day, Year) <b>5/17/99</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL PURCELL, JHRMC 4940 BARNER AVE, BALTIMORE MD 21224</b>									
	31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <b>Bruce G. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

ITEM#26 PER PHYS. G771 5-20-99 J.A.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRED A FLORENCE YANCEY

2. Date of Death

April 29 1999

3. Time of Death

12:40 AM

4a. Facility Name (If not institution, give street and number)

3796 Castle Drive

4b. City, Town, or Location of Death

Hampstead

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

227-10-8496

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 14, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Pa.

10b. County

York

10c. City, Town or Location

Red Lion

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

516 El Dorado Drive

10f. Zip Code

21074

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Everette P. Weddle

18. Mother's Name (First, Middle, Maiden Surname)

Pearl M. Epperly

19a. Informant's Name/Relationship (Type, Print)

Everett E. Yancey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

516 El Dorado Dr., Red Lion, Pa. 17356

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

5/3/99

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

John H. Burkauskas

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Chronic obstructive pulmonary disease

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pulmonary fibrosis

years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

SONS Residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Deogracias V. Faustino, M.D., P.A.

29c. License number

012901

29d. Date signed (Month, Day, Year)

4/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deogracias V. Faustino, M.D., P.A., 4111 Lwr. Beckleysville Rd., Hampstead, Md. 21074

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 20 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16252

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harry George Zukowski</b>				2. Date of Death Month <b>May</b> Day <b>18</b> Year <b>1999</b>				3. Time of Death <b>2:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Genesis Cromwell</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-03-7780</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>2/13/1913</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10e. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent											
10e. State <b>MD</b>				10b. County <b>N/A</b>				10c. City, Town or Location <b>Baltimore</b>			
10e. Street and Number <b>3542 Woodring Avenue</b>				10f. Zip Code <b>21234</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steel Worker</b>				16b. Kind of Business/Industry <b>Steel Company</b>			
17. Father's Name (First, Middle, Last) <b>Stanley Zukowski</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Leona Wozniak</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Anna Zukowski</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3542 Woodring Avenue Baltimore, Maryland 21234</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Stanilaus Cemetery</b>				Date <b>5/21/99</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PNEUMONIA</b> Due to (or as a consequence of): <b>DEHYDRATION</b> Due to (or as a consequence of): <b>FAILURE TO THRIVE.</b> Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1</b> Dementia <b>2</b> Failure to thrive <b>3</b> Dehydration <b>4</b> Pneumonia											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA.</b>											
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown											
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No							
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D52228</b>				29d. Date signed (Month, Day, Year) <b>5/19/99.</b>			
30. Name and address of person who completed cause of death (Part 23a) (Type, Print) <b>3007 C. Northern Pkwy. Baltimore, Maryland 21214</b>											
31. Date filed (Month, Day, Year) <b>MAY 20 1999</b>				32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

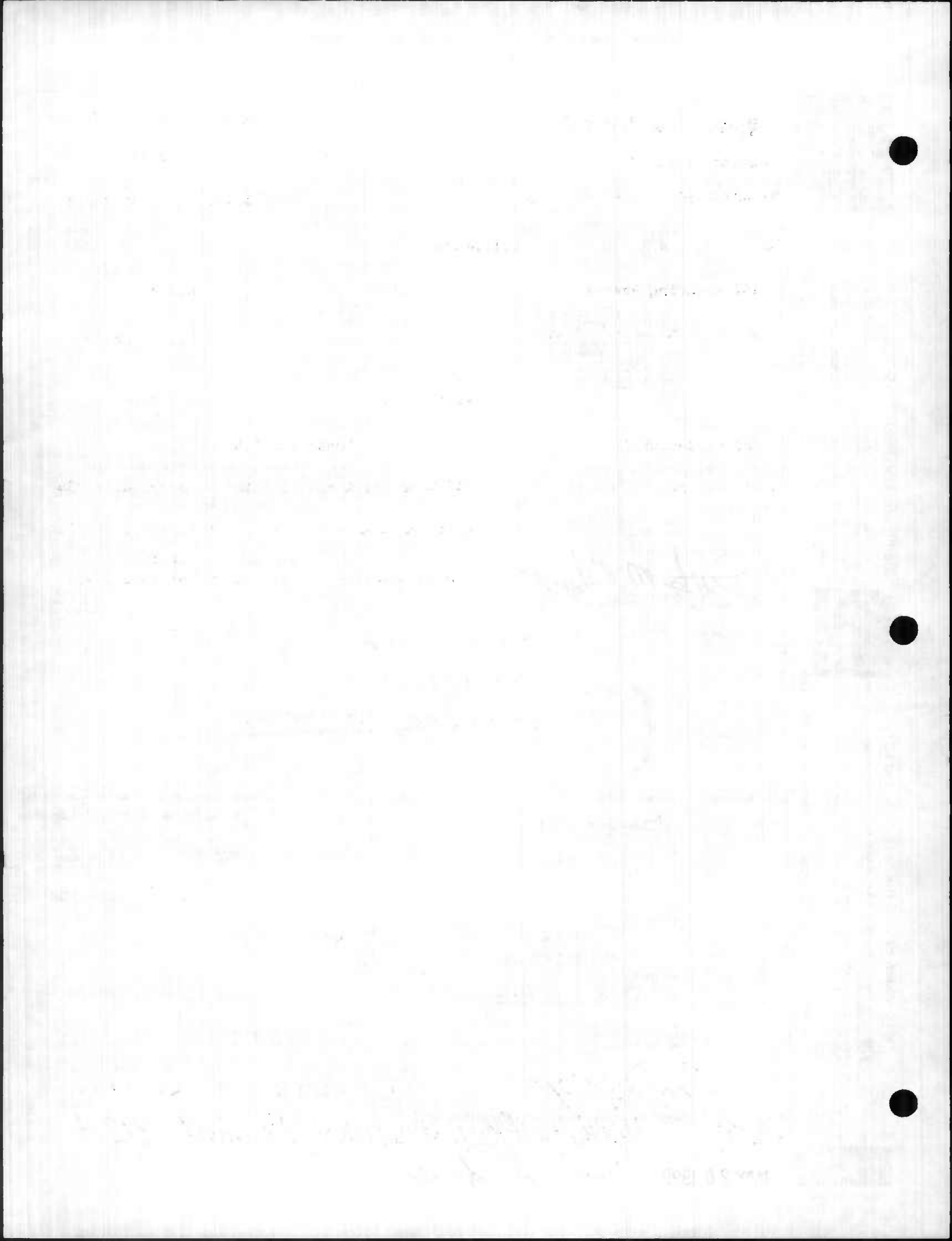
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16253

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lois M. Blake</b>				2. Date of Death Month: <b>May</b> Day: <b>7</b> Year: <b>1999</b>				3. Time of Death <b>12:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Southern Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Clinton</b>				4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>577 20 9981</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 3, 1921</b>		9. Birthplace (State or Foreign Country) <b>Washington DC</b>	
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1</b> Yes <b>2</b> No				10e. Street and Number <b>70 Village Street</b>				10f. Zip Code <b>20602</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) <b>11th</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food Clerk</b>				16b. Kind of Business/Industry <b>Retail Store</b>				17. Father's Name (First, Middle, Last) <b>Walter Staub</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie Colburn</b>				19a. Informant's Name/Relationship (Type, Print) <b>A. William Blake, Jr. (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>607 West Bay Front Road, Lothian, MD 20711</b>	
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery May 10, 1999 Suitland, Maryland</b>				20c. Location - City or Town, State	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Kelli R. Patter</i>				22. Name and Address of Facility <b>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>UNEXPECTED</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Upper GI bleed, ASCVD</b> <b>Alzheimer's Disease</b>	
	23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown				24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)				27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D19431</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>5/7/99</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Frank M. Ryan MD 11701 Livingston Rd #203 Ft. Washington MD 20744</b>				31. Date filed (Month, Day, Year) <b>MAY 11 1999</b>	
	32. Registrar's Signature <i>[Signature]</i>				33. State Registrar				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16254

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Neil ARMOUR			2. Date of Death Month Day Year May 2, 1999		3. Time of Death 0600		
	4e. Facility Name (If not institution, give street and number) 10650 Ward Road			4b. City, Town, or Location of Death Dunkirk		4c. County of Death Calvert		
Funeral Director	5. Social Security Number 236 56 4166		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Nov 4, 1937	
	10a. State MD		10b. County Calvert		10c. City, Town or Location Dunkirk		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 10650 Ward Road			10f. Zip Code 20754		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-60		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Engineer		16b. Kind of Business/Industry U.S. Gov't.			
	17. Father's Name (First, Middle, Last) John William Armour			18. Mother's Name (First, Middle, Maiden Surname) Lucille Effie Radabaugh				
	19a. Informant's Name/Relationship (Type, Print) Patricia J. Armour/wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 318, Dunkirk, MD 20754				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, VA		Date 5-7-99	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.							minutes years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/P Abdominal Aorta - Iliac Arteries Repair 1994 Hyperlipidemia							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Gerald P. Sterner M.D.		29c. License number D17245		29d. Date signed (Month, Day, Year) May 3, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald Sterner, M.D. Owings, MD 20736								
31. Date filed (Month, Day, Year) MAY 05 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



99 16255

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MABEL FRANCES MORGAN BREUNINGER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>May 7 1999</b>		3. TIME OF DEATH <b>0300 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-74-7913</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>98</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>February 27, 1901</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Calvert Manor Healthcare Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rising Sun</b>	
9c. COUNTY OF DEATH <b>Cecil</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>	
10c. CITY, TOWN OR LOCATION <b>Charlestown</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>60 Cecil Road</b>	
10f. ZIP CODE <b>21914</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Her own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Albert S. Morgan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Matilda Ann Whitman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dr. Ruth Ann Breuninger/Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 361, Charlestown, MD 21914</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fairview Cemetery May 12 1999</b>			
20c. LOCATION — City or Town, State <b>Coatesville, Pennsylv.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>Crouch Funeral Home 127 South Main Street, North East, MD 21901</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b> DUE TO (OR AS A CONSEQUENCE OF): <b>A.S.C.V.D.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Cerebrovascular Accident</b> b. <b>A.S.C.V.D.</b> c. d.  Approximate Interval Between Onset and Death <b>hours</b> <b>years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>May 7 1999</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Neil R. Taylor Jr MD</b>				29c. LICENSE NUMBER <b>0-11115</b>			
29d. DATE SIGNED (Month, Day, Year) <b>5-7-99</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Neil R. Taylor Jr MD, Calvert Healthcare Center, Rising Sun, MD 21911</b>			
31. DATE FILED (Month, Day, Year) <b>MAY 10 1999</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

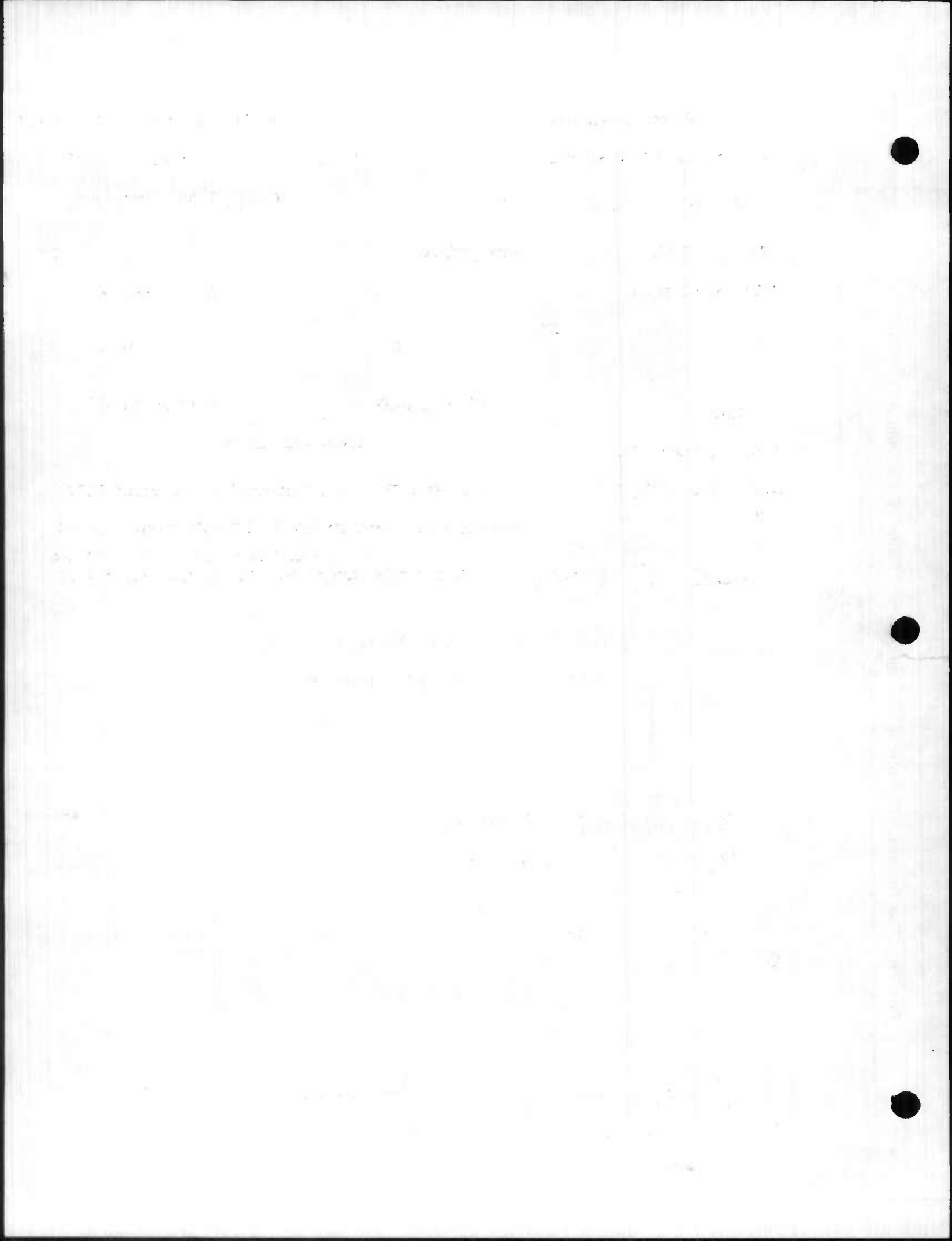
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16256

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Walter Bond, Jr.				2. Date of Death Month Day Year April 27, 1999		3. Time of Death 10:30 A.M.	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 212 62 1733		6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F XX		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) Feb 4, 1955	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County P.G.		10c. City, Town or Location Forestville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2529 Oak Glen Way		10f. Zip Code 20747		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Floor Installer		16b. Kind of Business/Industry Self Employed			
	17. Father's Name (First, Middle, Last) James W. Bond, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Irene Wilkerson			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nancy Bond (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2529 Oak Glen Way, Forestville, Maryland 20747			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery May 1, 1999 Clinton, Maryland		20c. Location - City or Town, State		20d. Date	
	21. Signature of Funeral Service Licensee Lee R. Patton				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage liver disease Due to (or as a consequence of): b. Chronic alcohol abuse Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal bleeding Hepatorenal syndrome						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier Walter M		29c. License number D43662		29d. Date signed (Month, Day, Year) 4/27/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE GEORGES HOSP - 3001 Hosp Drive 1 Cheverly MD 20781								
31. Date filed (Month, Day, Year) APR 29 1999		32. Registrar's Signature B. Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16257

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dorothy Carpenter</b>		2. Date of Death Month <b>MAY</b> Day <b>01</b> Year <b>1999</b>		3. Time of Death <b>2325</b>
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital</b>		4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>
Funeral Director	5. Social Security Number <b>212-38-4377</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>October 31, 1907</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Elkton</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>105 Gilpin Avenue</b>		10f. Zip Code <b>21921</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>teacher</b>		16b. Kind of Business/Industry <b>Education</b>
	17. Father's Name (First, Middle, Last) <b>William H. Hooper</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Eaton Hooper</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Richard T. Boyle / son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>105 Gilpin Avenue, Elkton, Maryland 21921</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hopewell Cemetery</b>		20c. Location - City or Town, State <b>May 5, 1999 Rising Sun, Maryland</b>
	21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Gee Funeral Home 259 E. Main St., Elkton, Maryland 21921</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. RESPIRATORY FAILURE</b> Due to (or as a consequence of): <b>b. ADULT RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of): <b>c. PNEUMONIA</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>1 WEEK</b> <b>2 WEEKS</b> <b>3 WEEKS</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>INSULIN DEPENDENT DIABETES MELLITUS</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D0051750</b>		29d. Date signed (Month, Day, Year) <b>07 MAY 99</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Mulligan 223 West Main Street, Elkton, MD 21921</b>					
31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

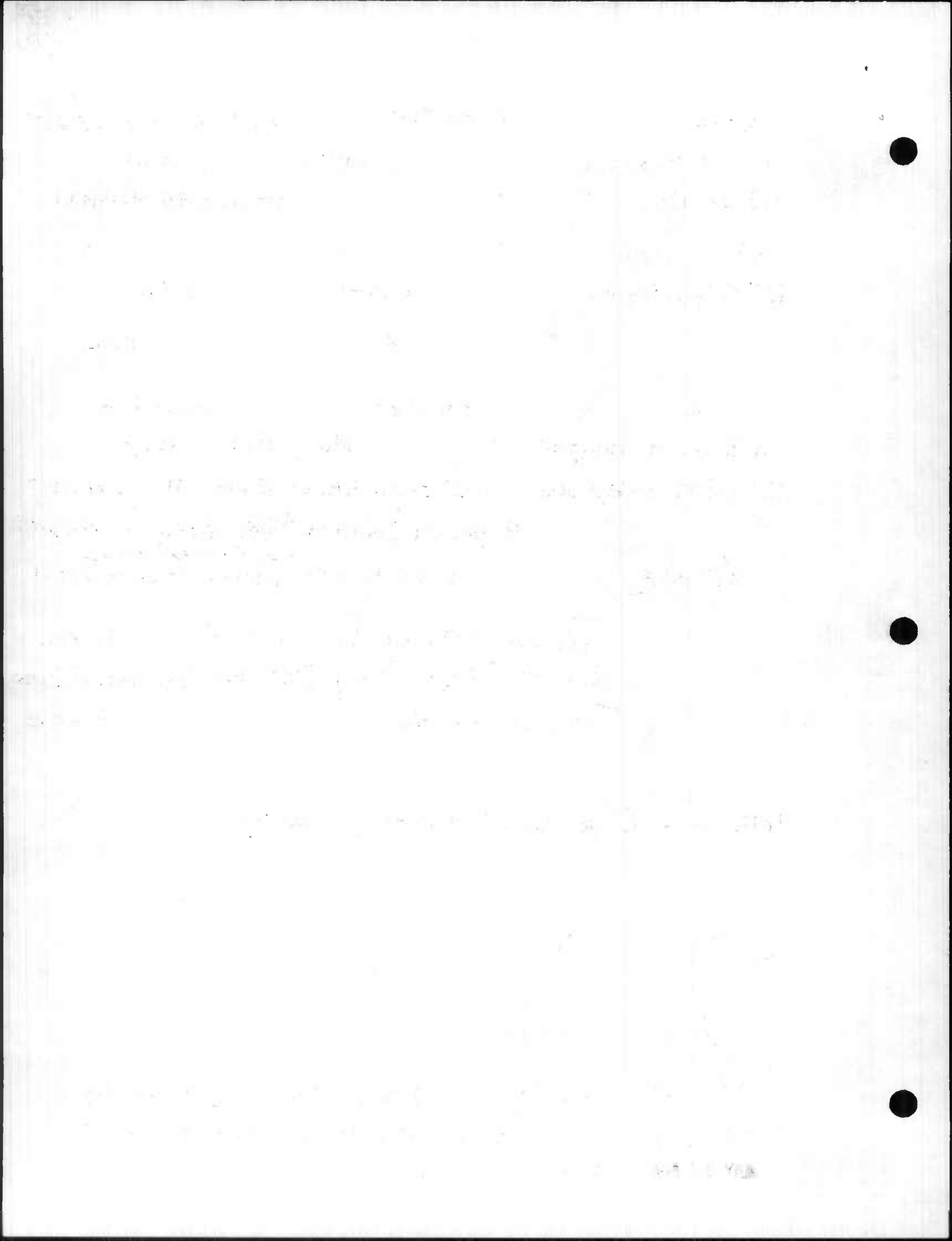
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16258

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen

C

Cordes

2. Date of Death

Month

Day

Year

April 26, 1999

3. Time of Death

9:00 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

579-22-1662

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 4, 1916

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

Maryland Prince George's

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8600 Mike Shapiro Drive #808

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Department Store

17. Father's Name (First, Middle, Last)

Alfred

Cordes

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Creamer

19a. Informant's Name/Relationship (Type, Print)

Emma C. Clendening (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6303 Foster St. District Heights MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery April 29, 1999 Suitland, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensed

22. Name and Address of Facility Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Rd Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24h

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Atherosclerosis

Due to (or as a consequence of):

10yr

Depression

Due to (or as a consequence of):

5yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laxmi Berwa M.D.

7700 Old Branch Avenue #C 101 Clinton, Maryland 20735

31. Date filed (Month, Day, Year)

APR 29 1999

32. Registrar's Signature

Berwa B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16259

AMEND: #26 PER MEO G772 6-21-99 WR.  
Amend #26, Sister's residence, 5/11/99 Certificate of Death

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <div style="text-align: center;">Robert Colleran</div>			2. Date of Death Month Day Year <div style="text-align: center;">May 9 99</div>			3. Time of Death <div style="text-align: center;">1036 A</div>			
	4a. Facility Name (If not institution, give street and number) <div style="text-align: center;">296 Rips Dr</div>			4b. City, Town, or Location of Death <div style="text-align: center;">LOTHIAN</div>			4c. County of Death <div style="text-align: center;">AA</div>			
<b>Funeral Director</b>	5. Social Security Number <div style="text-align: center;">080 22 2028</div>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <div style="text-align: center;">73 Yrs.</div>		8. Date of Birth (Month, Day, Year) <div style="text-align: center;">March 15, 1926</div>		9. Birthplace (State or Foreign Country) <div style="text-align: center;">New York</div>	
	Usual Residence of Decedent									
<b>To Be Completed by Funeral Director</b>	10a. State <div style="text-align: center;">MD</div>		10b. County <div style="text-align: center;">Suffolk</div>		10c. City, Town or Location <div style="text-align: center;">Brentwood</div>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <div style="text-align: center;">151 Charter Oaks Ave</div>				10f. Zip Code <div style="text-align: center;">11717</div>		10g. Citizen of What Country? <div style="text-align: center;">United States</div>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <div style="text-align: center;">White</div>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <div style="text-align: center;">12</div> College (1-4 or 5+) <div style="text-align: center;">2</div>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <div style="text-align: center;">Machinist</div>			16b. Kind of Business/Industry <div style="text-align: center;">Aerospace</div>			
	17. Father's Name (First, Middle, Last) <div style="text-align: center;">Peter Francis Colleran</div>					18. Mother's Name (First, Middle, Maiden Surname) <div style="text-align: center;">Helen Mary Smith</div>				
<b>To Be Completed by Physician/Medical Examiner</b>	19a. Informant's Name/Relationship (Type, Print) <div style="text-align: center;">Elizabeth Colleran (WIFE)</div>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <div style="text-align: center;">151 Charter Oaks Ave, Brentwood, N.Y. 11717</div>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <div style="text-align: center;">Washington Memorial Park</div>				20c. Location - City or Town, State <div style="text-align: center;">Mt. Sinai, New York</div>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="text-align: center;">e. <u>CARCINOMA COLON</u> Due to (or as a consequence of):</div> <div style="text-align: center;">f.  Due to (or as a consequence of):</div> <div style="text-align: center;">g.  Due to (or as a consequence of):</div> <div style="text-align: center;">h.  Due to (or as a consequence of):</div>									
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <div style="text-align: center;">SCENE Sister's residence</div>									
<b>Physician /Medical Examiner</b>	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <div style="text-align: center;">M</div>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
<b>State Registrar</b>	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <div style="text-align: center;">Deputy William P. Jones, MD</div>				29c. License number <div style="text-align: center;">D06054</div>		29d. Date signed (Month, Day, Year) <div style="text-align: center;">5/10/99</div>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <div style="text-align: center;">William P. Jones, MD 695 American 21035</div>									
31. Date filed (Month, Day, Year) <div style="text-align: center;">MAY 11 1999</div>										
32. Registrar's Signature <div style="text-align: center;">Benita B. Sparks</div>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16260

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHRYN MARY CARTER</b>				2. Date of Death Month <b>MAY</b> 2, Day <b>1999</b> Year				3. Time of Death <b>2158 pm</b>			
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Pr. Frederick</b>				4c. County of Death <b>Calvert</b>			
Funeral Director	5. Social Security Number <b>217-68-8799</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5/2/99</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>			
	Usual Residence of Decedent				10a. State <b>MD</b>				10b. County <b>Calvert</b>		10c. City, Town or Location <b>5655 Huntingtown Road, Huntingtown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street end Number <b>5655 Huntingtown Road</b>				10f. Zip Code <b>20639</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
	14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			
	17. Father's Name (First, Middle, Last) <b>George Milan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Mary Nahay</b>				16b. Kind of Business/Industry <b>Plumbing Company</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Merritt Carter/spouse</b>				19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) <b>5655 Huntingtown Road, Huntingtown, MD</b>				20c. Location - City or Town, State <b>Dunkirk, MD</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>S. Memorial Gdns</b>				20c. Date <b>5/5/99</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Raymond Funeral Home, P.A. P.O. Box 121, Dunkirk, MD 20754</b>				23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>MEASTATIC CARCINOMA</b> Due to (or as a consequence of): b. <b>CARCINOMA OF BREAST</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>MORE THAN 1 MONTH</b> <b>9 MONTHS</b>			
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>MEASTATIC CARCINOMA</b> Due to (or as a consequence of): b. <b>CARCINOMA OF BREAST</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>MORE THAN 1 MONTH</b> <b>9 MONTHS</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Were en autopsies performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>			
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street end Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				
29c. License number <b>D 50653</b>				29d. Date signed (Month, Day, Year) <b>5-3-1999</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GYAN CHAND SURANA 5851 DEALE CHURCHTON ROAD DEALE M.D. 20751</b>				
31. Date filed (Month, Day, Year) <b>MAY 04 1999</b>				32. Registrar's Signature 				33. State Registrar <b>15</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

16261

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Marguerite L. Chamblee</b>				2. Date of Death Month <b>May</b> Day <b>7</b> Year <b>1999</b>		3. Time of Death <b>6:55pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Calvert Manor Healthcare Center</b>				4b. City, Town, or Location of Death <b>Rising Sun</b>		4c. County of Death <b>Cecil</b>	
5. Social Security Number <b>577-20-6548</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 2, 1909</b>	
9. Birthplace (State or Foreign Country) <b>Washington DC</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Rising Sun</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1881 Telegraph Rd.</b>				10f. Zip Code <b>21911</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Charles R. Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret A. Bland</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Betty Lee McHale, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>411 Arbour Dr., Newark DE 19713</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodbury Memorial Park</b>		20c. Location - City or Town, State <b>May 11 1999 Clarksboro NJ</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Robert T. Jones and Foard, Inc. 122 West Main St. Newark DE 19711</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebral Vascular Accident</b> Due to (or as a consequence of): <b>Hypertension</b> Due to (or as a consequence of): <b>Atrial Fibrillation</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Dementia</b>							
Approximate Interval Between Onset and Death <b>yrs</b> <b>yrs</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
				28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>043198</b>		29d. Date signed (Month, Day, Year) <b>05/08/99</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>James S. Ley, MD 412 Suburban Drive, Newark DE 19711</b>							
31. Date filed (Month, Day, Year) <b>MAY 10 1999</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

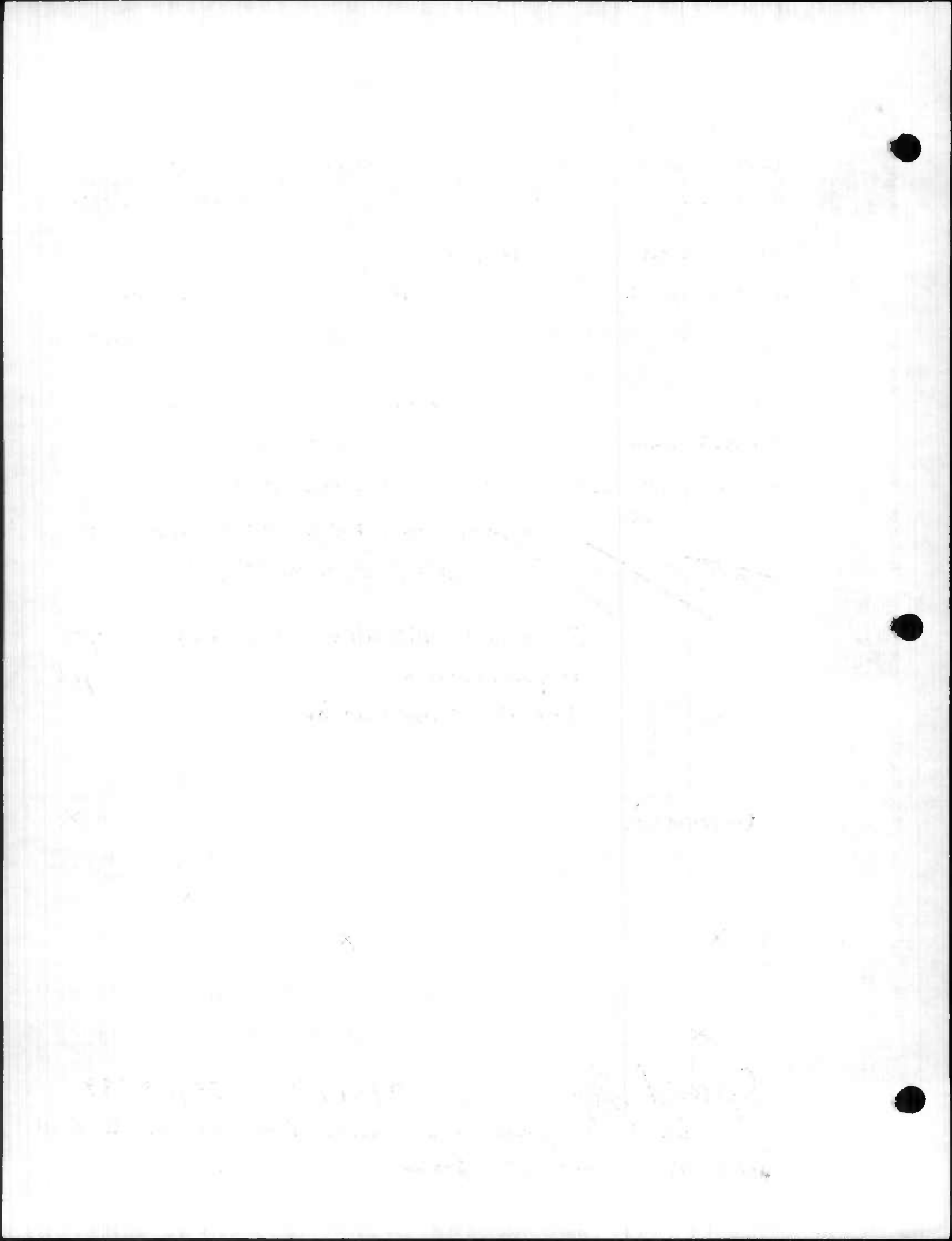
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16262

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PINK JESSIE COOK, JR.</b>				2. Date of Death Month Day Year <b>MAY 03 1999</b>		3. Time of Death <b>0415</b>		
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital of Cecil County</b>				4b. City, Town, or Location of Death <b>Elkton</b>		4c. County of Death <b>Cecil</b>		
Funeral Director	5. Social Security Number <b>241-66-1128</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 26, 1943</b>		
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>North East</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2343 Theodore Road</b>		10f. Zip Code <b>21901</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) _____		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Auto parts rework coordinator</b>		16b. Kind of Business/Industry <b>automobile manufacturer</b>					
17. Father's Name (First, Middle, Last) <b>Pink Jessie Cook, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Sutton</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Shelia R. Cook / Spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2343 Theodore Road, North East, MD 21901</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>North East Methodist Cem.</b>		Date <b>May 6 1999</b>		20c. Location - City or Town, State <b>North East, Maryland</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Crouch Funeral Home</b> <b>127 South Main Street, North East, MD 21901</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>LUNG CANCER</b>		Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____		Approximate Interval Between Onset and Death <b>YEARS</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D0053034</b>		29d. Date signed (Month, Day, Year) <b>5/3/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARC SCHEINER MD 223 W. MAIN ST ELKTON MD</b>		31. Date filed (Month, Day, Year) <b>MAY 05 1999</b>		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16263

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Benton James Groves				2. Date of Death Month Day Year APRIL 26, 1999				3. Time of Death 2000	
	4a. Facility Name (If not institution, give street and number) 9801 CONE COURT				4b. City, Town, or Location of Death UPPER MARLBORO				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 579 10 7051		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Feb 4, 1916		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County P.G.		10c. City, Town or Location Upper Marlboro				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 9801 Cone Court				10f. Zip Code 20772		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistical Clerk				16b. Kind of Business/Industry Federal Housing Admin.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James Groves				18. Mother's Name (First, Middle, Maiden Surname) Ethel Yowell					
	19a. Informant's Name/Relationship (Type, Print) Robert Groves (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12519 Knowledge Lane, Bowie, Maryland 20715					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. Date April 30, 1999		20d. Location - City or Town, State Cheltenham, Maryland			
	21. Signature of Funeral Service Licensee St. E. Sill				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735					
Physician /Medical Examiner	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):									
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Mario F. Golie M.D.		29c. License number D33954		29d. Date signed (Month, Day, Year) APRIL 27, 1999				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785										
31. Date filed (Month, Day, Year) APR 29 1999		32. Registrar's Signature B. Smith								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23b or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



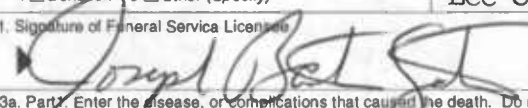
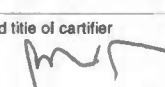
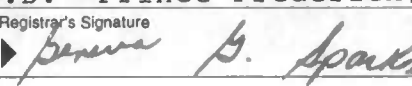
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16264

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA DAVIS</b>				2. Date of Death Month Day Year <b>APRIL 27, 1999</b>		3. Time of Death <b>0557 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>PRINCE FREDERICK</b>		4c. County of Death <b>CALVERT</b>	
Funeral Director	5. Social Security Number <b>217-42-4571</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN. 27, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Huntingtown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>2175 Kings Landing Road</b>		10f. Zip Code <b>20639</b>		10g. Citizen of What Country? <b>U. S. A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>At Home</b>			
	17. Father's Name (First, Middle, Last) <b>Fitchell Lee Merrix</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Lee Wardrup</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Cheryl Jodoin/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2175 Kings Landing Rd., Huntingtown, MD 20639</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		20c. Location - City or Town, State <b>Clinton, Maryland</b>		20d. Date <b>APRIL 30, 1999</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd. Owings, MD 20736</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. myocardial infarction</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>diabetes mellitus</b>							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>048314</b>		29d. Date signed (Month, Day, Year) <b>4/27/99</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Paul Pomilla, M.D. Prince Frederick, MD 20678</b>								
31. Date filed (Month, Day, Year) <b>APR 30 1999</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16265

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NANCY LEE DWYER</b>				2. Date of Death Month Day Year <b>MAY 5, 1999</b>		3. Time of Death <b>2015</b>		
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>		
Funeral Director	5. Social Security Number <b>231 50 7060</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b>		8. Date of Birth (Month, Day, Year) <b>July 19, 1941</b>		
	9. Birthplace (State or Foreign Country) <b>VA</b>		10a. State <b>MD</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Huntingtown</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>2360 Holland Cliff Road</b>		10f. Zip Code <b>20639</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>11</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>housewife</b>		16b. Kind of Business/Industry <b>own home</b>		17. Father's Name (First, Middle, Last) <b>Hunter Hall</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Newman</b>	
19a. Informant's Name/Relationship (Type, Print) <b>James F. Dwyer, Sr./husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as 10 above</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary Christian Church</b>		20c. Location - City or Town, State <b>Ashland, VA</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rausch Funeral Home, Owings, MD 20736</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. coronary artery Disease.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>2 months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>(1) Insulin Dependent Diabetes Mellitus</b> <b>(2) S/P coronary artery Bypass surgery</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>May 5, 1999</b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Dr. Anwar Munshi M.D.</b>		29c. License number <b>D 19427</b>		29d. Date signed (Month, Day, Year) <b>5/6/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Anwar Munshi M.D. 100 Hospital Rd Prince Frederick, Md 20678</b>		31. Date filed (Month, Day, Year) <b>MAY 07 1999</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16266  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Elaine DOWE

2. Date of Death

Month Day Year  
April 30, 1999

3. Time of Death

12:20 am

4a. Facility Name (If not institution, give street and number)

2311 Carter Avenue

4b. City, Town, or Location of Death

Dunkirk

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

218 16 3460

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep. 25, 1925

9. Birthplace (State or Foreign Country)

Cumberland, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Dunkirk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2311 Carter Avenue

10f. Zip Code

20754

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Clarence C

Peer

18. Mother's Name (First, Middle, Maiden Surname)

Lillie V Newlin

19a. Informant's Name/Relationship (Type, Print)

Leslie G. West

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 41, Stafford Rd., Barstow, MD 20610

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

5-3-99

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

William R. [Signature]

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute/Chronic Respiratory Failure

Days

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Asthma

Diabetes mellitus Type 2.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gerald P. Sterner MD

29c. License number

D17245

29d. Date signed (Month, Day, Year)

April 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gerald Sterner, MD

Owings, MD 20736

31. Date filed (Month, Day, Year)

APR 30 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16267

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Chalmer DeFibaugh				2. Date of Death Month Day Year May 3, 1999		3. Time of Death 4:37 P.M.	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 174 18 2667		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 14, 1921	9. Birthplace (State, Country) PA.
	Usual Residence of Decedent				10c. City, Town or Location Camp Springs		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MD		10b. County P.G.		10f. Zip Code 20748		10g. Citizen of What Country? United States		
10e. Street and Number 5707 Hartwell Street		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) Charles W. DeFibaugh				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Black				
19a. Informant's Name/Relationship (Type, Print) Dora DeFibaugh (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5707 Hartwell Street, Camp Springs, MD 20748				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cemetery		20c. Location - City or Town, State Suitland, Maryland		20d. Date of Disposition May 6, 1999
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735				
23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY DISTRESS SYNDROME Due to (or as a consequence of): CONGESTIVE HEART FAILURE Due to (or as a consequence of): CORONARY ARTERY DISEASE Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 13072		29d. Date signed (Month, Day, Year) 5/4/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gurbux H. Nachnani, M.D. 8926 Woodyard Road #601, Clinton, MD 20735								
31. Date filed (Month, Day, Year) MAY 07 1999				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

HENRY ELLSWORTH DEMARR

2. Date of Death

MAY 9 1999

3. Time of Death

3:50AM

4a. Facility Name (If not institution, give street and number)

7229 BENEDICT AVENUE

4b. City, Town, or Location of Death

BENEDICT

4c. County of Death

CHARLES

5. Social Security Number

220-24-0534

6. Sex

XXM 2□ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 26, 1928 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Benedict

10d. Inside City Limits

1□ Yes 2□ No

10e. Street and Number

7229 Benedict Ave.

10f. Zip Code

20612

10g. Citizen of What Country?

USA

11. Marital Status

1□ Never Married 2□ Married

3□ Widowed 4□ Divorced

12. Was Decedent Ever in U.S.

1□ Yes 2□ No

If Yes, Give Year or Dates:

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2□ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

7

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chief of Police

18b. Kind of Business/Industry

Law Officer

17. Father's Name (First, Middle, Last)

John Henry DeMarr

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Tippet DeMarr

19a. Informant's Name/Relationship (Type, Print)

Margaret A. DeMarr/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 24 Benedict, MD 20612

20a. Method of Disposition

1□ Burial 2□ Cremation 3□ Removal from State

4□ Donation 5□ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Memorial Gar. 5/12/99 Waldorf, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00817  
Danton C. Echols III

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME P.A.  
P.O. BOX 567 LA PLATA, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COLON CANCER  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1□ Yes 2□ No 3□ Probably 4□ Unknown

24a. Was an autopsy performed?

1□ Yes 2□ No

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2□ No

25. Was case referred to medical examiner?  
1□ Yes 2□ No

26. Place of Death (Check only one)

Hospital:

1□ Inpatient

2□ ER/Outpatient

3□ DOA

Other:

4□ Nursing Home

5□ Residence

6□ Other (Specify)

27. Manner of Death

1□ Natural

5□ Pending Investigation

2□ Accident

3□ Suicide

4□ Homicide

6□ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1□ Yes 2□ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)

1□ Medical Examiner

2□ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Krishan M. Mathur

29c. License number

D28352

29d. Date signed (Month, Day, Year)

MAY 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR, MD., P.O. BOX 2729, LA PLATA, MD 20646

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature

Krishan M. Mathur

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16269

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELLA MAE ELLIOTT

2. Date of Death

April 30, 1999

3. Time of Death

2152

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

198-18-1908

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 3, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

DE

10b. County

Sussex

10c. City, Town or Location

Millsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

C E 40 Careys Estates

10f. Zip Code

19966

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

nurses aid

16b. Kind of Business/Industry

Healthcare

17. Father's Name (First, Middle, Last)

Charles Patterson

18. Mother's Name (First, Middle, Maiden Surname)

Margaret June Roberts

19a. Informant's Name/Relationship (Type, Print)

Lillian A. Marsh (daughter) 15 Champlain Ave. Wilmington, DE. 19804

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chester-Bethel Cem.

Date

5/7/99

20c. Location - City or Town, State

Wilmington, DE.

21. Signature of Funeral Service Licensee

M00510

22. Name and Address of Facility

Galena Funeral Home of Stephen Schaech  
118 West Cross St. Galena, MD. 21635

23a. Part I. Enter the disease, or diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Aspiration Pneumonia

Due to (or as a consequence of):

hours

b. Cerebral Vascular Accident

Due to (or as a consequence of):

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D36783

29d. Date signed (Month, Day, Year)

4/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey L. Hanta, Salisbury, MD

31. Date filed (Month, Day, Year)

MAY 06 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended item 8, Cecil Co. May 12, 1999

Certificate of Death

Reg. No.

89 16270

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JANE M. FINNAN</b>		2. Date of Death Month Day Year <b>May 10 1999</b>		3. Time of Death <b>7:08 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Calvert Manor Nursing Home 1881 Telegraph Rd. Rising Sun MD</b>		4b. City, Town, or Location of Death <b>Rising Sun MD</b>		4c. County of Death <b>Cecil</b>
Funeral Director	5. Social Security Number <b>221-01-4805</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>April 22, 1918</b>	9. Birthplace (State or Foreign Country) <b>Delaware</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>DE</b>	10b. County <b>New Castle</b>	10c. City, Town or Location <b>Wilmington</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>2009 Wildwood Drive</b>		10f. Zip Code <b>19805</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Lady</b>		16b. Kind of Business/Industry <b>Wilm Country Store</b>
17. Father's Name (First, Middle, Last) <b>Elmer Price</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lida Bradway</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Lawrence C Finnann (Son)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>39 High St. Port Deposit, MD 21904</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Silverbrook Mem. Park 5/13/99</b>		20c. Location - City or Town, State <b>Wilmington DE</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>McCrery Funeral Homes, Inc. 3924 Concord Pk, Wilm. DE 19803</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <b>Respiratory Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Lung Tumor</b> Due to (or as a consequence of):</p> <p>c. <b>ALZHEIMER'S Dis.</b> Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>3 wks.</b></p> <p><b>&gt; 1 yr.</b></p> </div> </div>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>NIDDM.</b>					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>			
29c. License number <b>D0948</b>		29d. Date signed (Month, Day, Year) <b>5/10/99</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Phillips, Masonic Building, Darlington, MD.</b>					
31. Date filed (Month, Day, Year) <b>MAY 11 1999</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16271

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence Viola Gilbert</b>				2. Date of Death Month <b>April</b> Day <b>28</b> Year <b>1999</b>				3. Time of Death <b>12:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>				4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>225 16 3271</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>96</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Mar. 26, 1903</b>		9. Birthplace (State or Foreign Country) <b>VA</b>		Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Calvert</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Prince Frederick</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>301 Overlook Drive</b>	
	10f. Zip Code <b>20678</b>				10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assistant Buyer</b>				16b. Kind of Business/Industry <b>Department Store</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>George H Arthur</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sara Elizabeth Dowdy</b>				19a. Informant's Name/Relationship (Type, Print) <b>E. Geraldine DeLodovico/daug.</b>	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as 10 above</b>				20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>	
To Be Completed by Physician/Medical Examiner	20c. Date <b>4-30-99</b>				20d. Location - City or Town, State <b>Covington, VA</b>				21. Signature of Funeral Service Licensee <b>Charles F. Bell</b>	
	22. Name and Address of Facility <b>Rausch Funeral Home, Owings, MD 20736</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>respiratory insufficiency</b> <b>pneumonia</b> <b>atrial fibrillation, insulin-dependent diabetes, renal insufficiency, chronic lymphocytic leukemia</b>				Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>A39522</b>	
	29d. Date signed (Month, Day, Year) <b>4/28/99</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Fears. 110 Hospital Rd. Pr. Frederick, MD 20678</b>				31. Date filed (Month, Day, Year) <b>APR 29 1999</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>[Signature]</b>				33. State Registrar <b>State Registrar</b>				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	
	35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				36. To Be Completed by Physician/Medical Examiner				37. To Be Completed by Physician/Medical Examiner	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16272

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma Watson Harkness				2. Date of Death April 30 Day 1999 Year				3. Time of Death 3 30 AM				
	4a. Facility Name (If not institution, give street and number) 4305 Broomes Island Road				4b. City, Town, or Location of Death Port Republic				4c. County of Death Calvert				
Funeral Director	5. Social Security Number 215 38 2554		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) January 9 1908 Maryland		
	Usual Residence of Decedent				10c. City, Town or Location Port Republic				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10a. State Maryland		10b. County Calvert		10e. Street and Number 4305 Broomes Island Road				10f. Zip Code 20676		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) teacher				16b. Kind of Business/Industry public school					
17. Father's Name (First, Middle, Last) Samuel Watson				18. Mother's Name (First, Middle, Maiden Surname) Ida Lois Russell									
19a. Informant's Name/Relationship (Type, Print) Arthur Harkness- son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4401 Broomes Island Road Port Republic Maryland 20676									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Christ Church Cemetery May				Date 1999		20c. Location - City or Town, State Port Republic Maryland 20676			
21. Signature of Funeral Service Licensee B. Rausch				22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic Maryland 20676									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. COMPLICATIONS OF ADVANCED PARKINSON'S DISEASE YEARS Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.													
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29b. Signature and title of certifier John H. Weigel				29c. License number D26358				29d. Date signed (Month, Day, Year) APRIL 30, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John H. Weigel, M.D. 110 Hospital Rd. Suite 310 Prince Frederick MD 20678													
31. Date filed (Month, Day, Year) MAY 03 1999				32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

16273

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annie Opal Hooper				2. Date of Death Month Day Year May 4, 1999		3. Time of Death 3:45 A.M.	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-24-8630		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 90		8. Date of Birth (Month, Day, Year) Jan 11 1909	
	9. Birthplace (State or Foreign Country) TN		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 8104 Sonar Road				10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home			
	17. Father's Name (First, Middle, Last) Ike Vinson				18. Mother's Name (First, Middle, Maiden Surname) Leathy Cummings			
	19a. Informant's Name/Relationship (Type, Print) Blanche K. Davis (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8104 Sonar Road, Clinton, Maryland 20735			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverside Cemetery		20c. Location - City or Town, State Woodbury, TN			
	21. Signature of Funeral Service Licensee D. S. S.				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) The Highway		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Rene E. Grace M.D.		29c. License number 002259		29d. Date signed (Month, Day, Year) May 4, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rene E. Grace M.D. 9131 Piscataway Road Suite 260 Clinton, MD 20735								
31. Date filed (Month, Day, Year) MAY 07 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

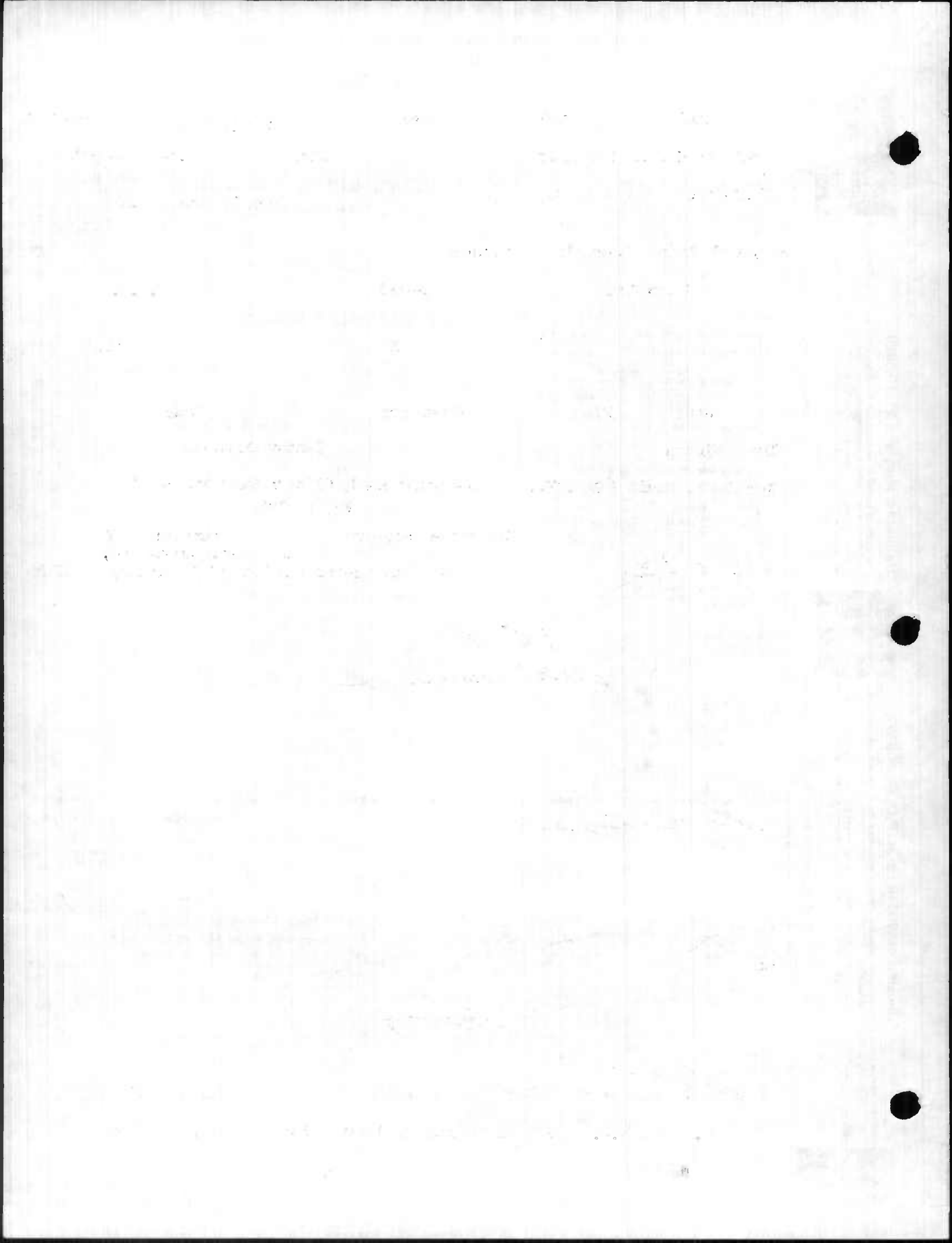
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

16274

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Samuel C. Hudson</u>				2. Date of Death Month <u>8</u> Day <u>8</u> Year <u>99</u>		3. Time of Death <u>8:15 AM</u>		
	4a. Facility Name (If not institution, give street and number) <u>Prince Georges Hospital Center</u>				4b. City, Town, or Location of Death <u>Chesley, MD</u>		4c. County of Death <u>WIA</u>		
Funeral Director	5. Social Security Number <u>217-32-1050</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>89</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>11/5/09</u>	9. Birthplace (State or Foreign Country) <u>Virginia</u>	
	Usual Residence of Decedent								
10a. State <u>MD</u>		10b. County <u>Prince Georges</u>		10c. City, Town or Location <u>Upper Marlboro</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <u>16401 Mt. Calvert Road</u>				10f. Zip Code <u>20772</u>		10g. Citizen of What Country? <u>USA</u>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>white</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Businessman</u>			16b. Kind of Business/Industry <u>Petroleum</u>		
17. Father's Name (First, Middle, Last) <u>John Price Hudson</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Nolian Harris</u>					
19a. Informant's Name/Relationship (Type, Print) <u>Donald Hudson/son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>16411 Mt. Calvert Road, Upper Marlboro, MD</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Cedar Hill Cemetery</u>		Date <u>5/12/99</u>		20c. Location - City or Town, State <u>Suitland, MD</u>			
21. Signature of Funeral Service Licensee <u>Michael C. Samuel</u>				22. Name and Address of Facility <u>Raymond Funeral Home, P.A. P.O. Box 121, Dunkirk, MD 20754</u>					
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Respiratory failure.</u> Due to (or as a consequence of):  b. <u>pneumonia</u> Due to (or as a consequence of):  c. <u>Sepsis</u> Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Possible stroke</u> <u>Renal Insufficiency.</u>								Approximate Interval Between Onset and Death	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Bijan Bahmanyar M.D.</u>		29c. License number <u>128759</u>		29d. Date signed (Month, Day, Year) <u>5/8/99</u>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>Bijan Bahmanyar 7311 Hanover Parkway #200 Greenbelt, MD 20770</u>									
31. Date filed (Month, Day, Year) <u>MAY 11 1999</u>				32. Registrar's Signature <u>B. Sparks</u>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200.

201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300.

301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400.

401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500.

501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600.

601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700.

701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800.

801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16275

|  |  |  |   |                             |  |  |  |                                   |  |
|--|--|--|---|-----------------------------|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Nancy Holcomb Heller   |  |   |                             | 2. Date of Death<br>Month May 9, Day 1999 Year   |  | 3. Time of Death<br>4:10AM   |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>8009 Woodyard Road   |  |   |                             | 4b. City, Town, or Location of Death<br>Clinton  |  | 4c. County of Death<br>Prince George's   |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>404 28 0237   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                             | 7. Age (In yrs. last birthday)<br>76 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 24, 1923   |                                   |  |
|  | 10a. State<br>MD   |  | 10b. County<br>P.G.   |                             | 10c. City, Town or Location<br>Clinton   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                   |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br>8009 Woodyard Road   |  |   |                             | 10f. Zip Code<br>20735   |  | 10g. Citizen of What Country?<br>United States   |                                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1944 1945   |                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: X |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Proofreader  |                             | 16b. Kind of Business/Industry<br>Company People's Insurance   |  |  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Vincent Boreing Hilcomb   |  |   |                             | 18. Mother's Name (First, Middle, Maiden Surname)<br>Susan Hodges  |  |  |                                   |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Robert L. Heller (HUSBAND)   |  |   |                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8009 Woodyard Road, Clinton, Maryland 20735   |  |  |                                   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>East Salem Cemetery   |                             | Date   |  | 20c. Location - City or Town, State<br>London, Kentucky  |                                   |  |
|  | 21. Signature of Funeral Service Licensee  |  |   |                             | 22. Name and Address of Facility<br>Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735  |  |  |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. METASTATIC BREAST CARCINOMA 3 1/2 YEARS<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |                             |  |  |  |                                   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                             |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                   |  |
|  |  |  |   |                             |  |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                   |  |
|  |  |  |   |                             |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                             |  |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M    |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |                             |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Harvey Katzen M.D.                            |   | 29c. License number<br>#201 |  | 29d. Date signed (Month, Day, Year)<br>May 10, 1999                                  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Harvey Katzen M.D. 8926 Woodyard Rd Clinton, Maryland 20735  |  |  |   |                             |  |  |  |                                   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>MAY 11 1999   |  | 32. Registrar's Signature<br>B. Sparks  |                             |  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

24



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16276

|  |  |                               |   |   |  |  |   |  |  |  |  |
|--|--|-------------------------------|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CAROLE EILEEN HOLT</b>                              |                               |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>8</b> Year <b>1999</b>   |  |   |  | 3. Time of Death<br><b>1345 pm</b>                           |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b> |                               |   |   | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>  |  |   |  | 4c. County of Death<br><b>Calvert</b>                        |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577 56 5545</b>  |                               | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 7, 1942</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>Wash., DC</b> |  |  |
|  | Usual Residence of Decedent  |                               |   |   |  |  |   |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Calvert</b> |   | 10c. City, Town or Location<br><b>Prince Frederick</b>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>85 Hospital Rd.</b>   |  |                               |   | 10f. Zip Code<br><b>20678</b>   |  |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>administrative supervisor</b> |  |  |   | 16b. Kind of Business/Industry<br><b>US Gov't.</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Walter Johannus Isaksen</b>  |  |                               |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Anne Boyd</b>  |  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Roberta I. Ridenour-sister</b>  |  |                               |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12915 Holdridge Rd., Wheaton, MD 20906</b>   |  |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |   |  | 20c. Location - City or Town, State<br><b>5-10-99 Alexandria, VA</b> |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                               |   |   | 22. Name and Address of Facility<br><b>Rausch Funeral Home, Owings, MD 20736</b>   |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Breast Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                               |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                               |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  |  |                               |   |   |  |  |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|  |  |                               |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |                               | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                            |  |  |
|  |  |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                               |   |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                               |   |   | 29c. License number<br><b>033123</b>   |  |   | 29d. Date signed (Month, Day, Year)<br><b>5-8-99</b>   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JONATHAN D. LOWENTHAL, M.D., PRINCE FREDERICK, MD 20678</b>   |  |                               |   |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 12 1999</b>  |  |                               | 32. Registrar's Signature<br>   |   |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16277

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence W. Jones

2. Date of Death

Month April 27, 1999 Year

3. Time of Death

3:05 AM

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

5. Social Security Number

225 05 3015

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year Sept 5, 1917

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29449 Charlotte Hall Road

10f. Zip Code

20622

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 ☐ No 1942-

If Yes, Give Year or Dates: 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Postal Worker

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Clarence Jones

18. Mother's Name (First, Middle, Maiden Surname)

Anna Hardy

19a. Informant's Name/Relationship (Type, Print)

Constance Alexander (DAUGHTER)

4518 40th St. Brentwood, Maryland 20722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

May 4, 1999 Maryland Veterans Cemetery

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

St. E. Sitt

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA STOMACH

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1-2 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA PROSTATE

CARCINOMA of Colon

Seizure Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

St. E. Sitt Attending

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

April 27 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVINKUMAR J PATEL MD 6 INDUSTRIAL DR PRESTON SB II WALDORF MD

31. Date filed (Month, Day, Year)

APR 30 1999

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16278

|  |   |   |  |   |  |   |                                |  |  |  |
|--|---|---|--|---|--|---|--------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Grace Kelly Johnson</i>  |   |  |   | 2. Date of Death<br>Month <i>May</i> Day <i>5</i> Year <i>1999</i> |   |                                |  | 3. Time of Death<br><i>5:35 PM</i>               |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Sunrise Care &amp; Rehabilitation Center</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>Elkton</i>              |   |                                |  | 4c. County of Death<br><i>Cecil</i>              |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>212-62-7143</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><i>92</i> Yrs.                   |   | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.                   |  |
|  | 6. Data of Birth (Month, Day, Year)<br><i>June 11, 1906</i>   |   | 9. Birthplace (State or Foreign Country)<br><i>Pennsylvania</i>            |   | 10a. State<br><i>Maryland</i>                                      |   | 10b. County<br><i>Cecil</i>    |  | 10c. City, Town or Location<br><i>Rising Sun</i> |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><i>481 Biggs Highway</i>  |  | 10f. Zip Code<br><i>21911</i>   |                                | 10g. Citizen of What Country?<br><i>USA</i>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4</i> Collegiate (1-4 or 5+)   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>  |   | 16b. Kind of Business/Industry<br><i>Own Home</i>   |  | 17. Father's Name (First, Middle, Last)<br><i>Hollis G. Kelly</i>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Margaret Rae</i>  |                                | 19a. Informant's Name/Relationship (Type, Print)<br><i>Paul D. Johnson/Son</i>   |  |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>54 Chestnut Drive Elkton, MD 21921</i>                                     |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Brookview Cemetery</i>   |  | 20c. Location - City or Town, State<br><i>5-10-99 Rising Sun, Maryland</i>  |                                | 21. Signature of Funeral Service Licensee<br><i>Richard L. Goodie</i>  |  |  |
| 22. Name and Address of Facility<br><i>R. T. Foard Funeral Home, P. A.<br/>111 S. Queen St., Rising Sun, MD 21911</i>  |   | 23a. Part I: Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>congestive heart failure</i><br>Due to (or as a consequence of):<br><i>mitral regurgitation</i><br>Due to (or as a consequence of):<br><i>ASCVD</i><br>Due to (or as a consequence of):<br><i>hypertension</i> |  | Approximate Interval Between Onset and Death<br><i>3 months</i><br><i>year</i><br><i>year</i><br><i>year</i>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |                                | 28a. Date of Injury (Month, Day, Year)   |  |  |
| 28b. Time of Injury<br><i>M</i>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
| 29b. Signature and title of certifier<br><i>W. Bruce Obenshain MD.</i>   |   | 29c. License number<br><i>D35779</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>5/5/99 May 5th, 1999</i>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>W. Bruce Obenshain 2515 Bohemia Ave, Cecilton, Md, 21913</i>   |                                | 31. Date filed (Month, Day, Year)<br><i>MAY 06 1999</i>  |  |  |
| 32. Registrar's Signature<br><i>P. Sparks</i>  |   |   |  |   |  |   |                                |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 16279

|  |   |                             |   |   |  |  |  |  |
|--|---|-----------------------------|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PAUL WOODALL LAKE</b>                    |                             |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>6</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>6:08pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b> |                             |   |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>  |  | 4c. County of Death<br><b>Cecil</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>221-24-7230</b>   |                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug 16 1936</b>                                      |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |                             |   |   |  |  |  |  |
| Usual Residence of Decedent  |   |                             |   |   |  |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Cecil</b> |   | 10c. City, Town or Location<br><b>Chesapeake City</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2941 Old Telegraph Rd.</b>  |   |                             |   | 10f. Zip Code<br><b>21915</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |                             |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>                          |  | 16b. Kind of Business/Industry<br><b>Farm Machinery</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ruben B. Lake</b>  |   |                             |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Woodall</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth Lake (wife)</b>  |   |                             |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21915 2941 Old Telegraph Rd. Chesapeake City MD.</b> |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bethel Cemetery</b>  |   | Date<br><b>5/9/99</b>  |  | 20c. Location - City or Town, State<br><b>Chesapeake City MD.</b>                              |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                             |   | 22. Name and Address of Facility<br><b>M00510 Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635</b>                         |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or instant failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br>f. <b>Diabetes Mellitus and stage I cardiomyopathy</b><br>Due to (or as a consequence of):<br>g.<br>Due to (or as a consequence of):<br>h.<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>{<br>Peripheral Vascular Disease<br>Renal Failure |   |                             |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral Vascular Disease</b><br><b>Renal Failure</b>   |   |                             |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                             |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                             | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                             | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how injury occurred  |   |                             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                             |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |                             | 29c. License number<br><b>025915</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>5-9-99</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barbara Parey MD P.O. Box 415 Cecilton, MD. 21913</b>   |   |                             |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>  |   |                             | 32. Registrar's Signature<br>   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

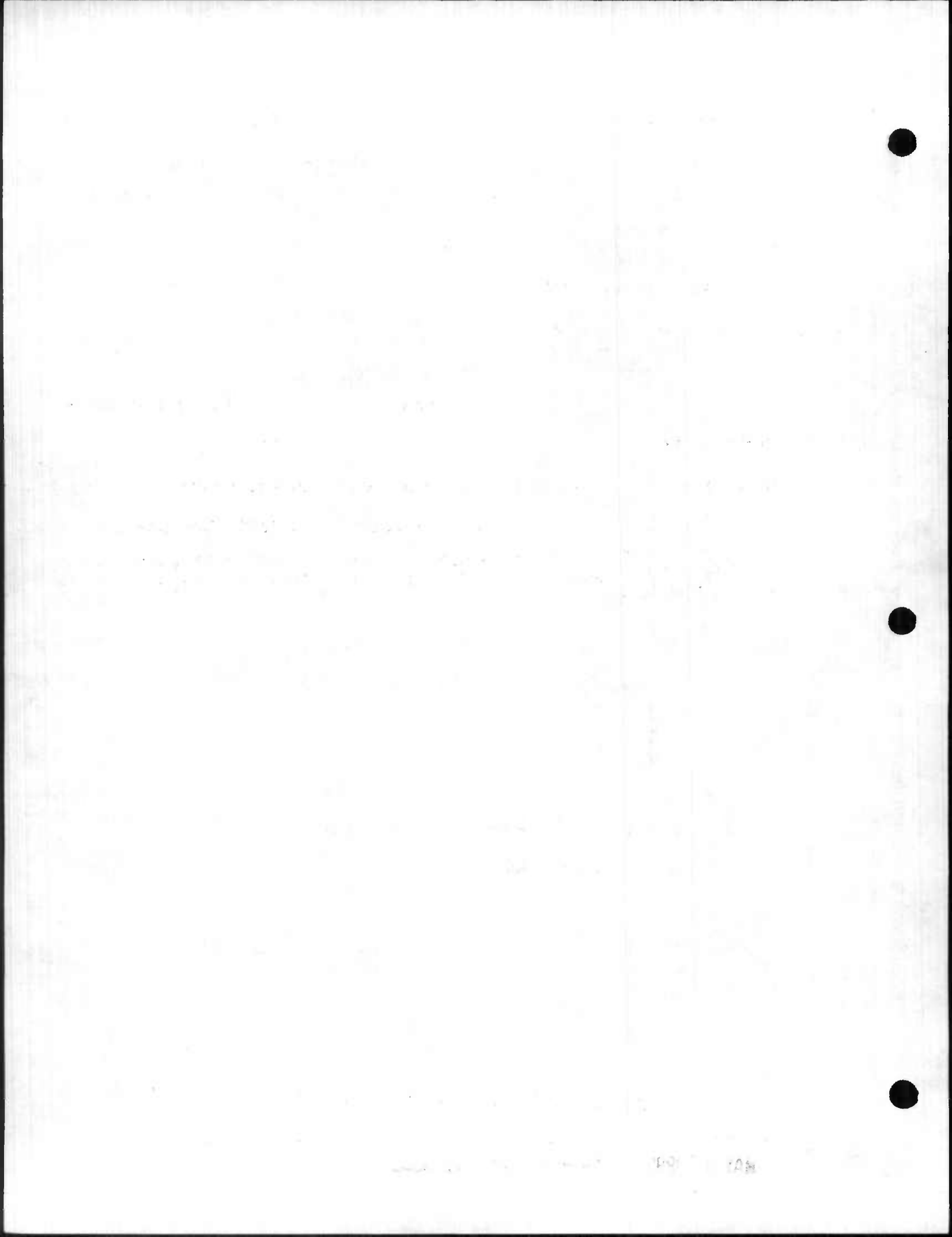
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar



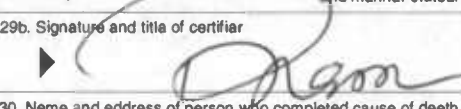
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16280

|   |  |   |  |  |   |  |   |  |
|---|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM WALLACE MINDER JR.</b>                      |   |  |  | 2. Date of Death<br>Month Day Year<br><b>May 4, 1999</b>        |  | 3. Time of Death<br><b>1900</b>                             |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b> |  | 4c. County of Death<br><b>Calvert</b>                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219 48 4389</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>52</b>                     |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 2, 1946</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Wash., DC</b>                                       |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Calvert</b>                                   |  | 10c. City, Town or Location<br><b>Chesapeake Beach</b>      |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>3318 Prowse Road</b>   |  | 10f. Zip Code<br><b>20732</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>      |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>carpenter</b>  |  | 16b. Kind of Business/Industry<br><b>construction</b>  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Wallace Minder, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Robertson</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Colleen E. Minder-wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as 10 above</b>   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Southern Mem. Gardens</b>  |  | 20c. Date<br><b>5-8-99</b>   |   | 20d. Location - City or Town, State<br><b>Dunkirk, MD</b>                    |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, Owings, MD 20736</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Cardiomyopathy Viral</b><br>Due to (or as a consequence of):<br>b. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>c. <b>Osteomyelitis Foot</b><br>Due to (or as a consequence of):<br>d. <b>Pericardial effusion</b> |  |   |  |  |   |  |   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral Vascular Disease</b><br><b>Renal insufficiency</b>   |  |   |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28. Date of Injury (Month, Day, Year)<br><b>May 4, 1999</b>                  |   |  |
| 28a. Time of Injury<br><b>M</b>   |  | 28b. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28c. Describe how Injury occurred  |   | 28d. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D37588</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/5/99</b>                         |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Rafik Nasr, M.D. prince Frederick, MD 20678</b>  |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39 16281

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joe Anderson Morris, Jr.

2. Date of Death

Month  
MAY

Day  
6

Year  
1999

3. Time of Death

3:56 AM

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

225-30-4032

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

8. Date of Birth

Month, Day, Year

9. Birthplace (State or Foreign Country)

July 5, 1927

10. Inside City Limits

☐ Yes ☒ No

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Capitol Heights

10e. Street and Number

904 Brooke Road

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Craftsman Press

17. Father's Name (First, Middle, Last)

Joe Morris

18. Mother's Name (First, Middle, Maiden Surname)

Pearl Robertson

19a. Informant's Name/Relationship (Type, Print)

Robert Morris (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

904 Brooke Road, Capitol Heights, Maryland 20743

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

May 11, 1999  
Maryland Veterans Cemetery

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Director

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA OF ESOPHAGUS

7 DAYS

Due to (or as a consequence of):

b. BILATERAL PLEURAL EFFUSION

7 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABOL POURHAMIDI, MD 8100 GOOD LUCK ROAD #6A, LANHAM, MD 20706

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature

Benita B. Sparks

State Registrar

JOE ANDERSON MORRIS  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8+1

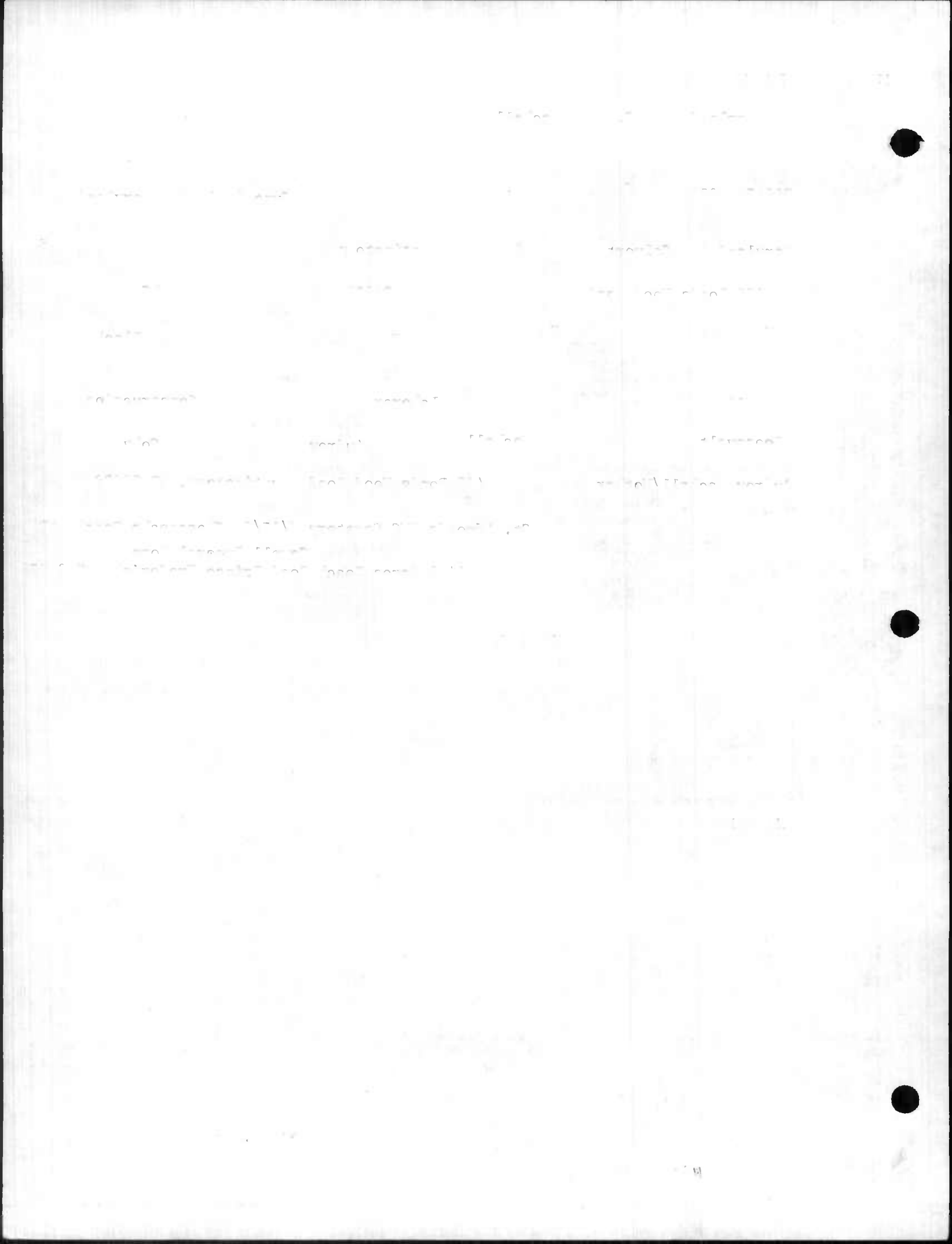
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



|  |  |  |   |                                 |  |  |                                      |  |  |  |
|--|--|--|---|---------------------------------|--|--|--------------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Ferland C. Mackall   |  |   |                                 | 2. Date of Death<br>Month Day Year<br>May 11, 1999   |  |                                      |  | 3. Time of Death<br>7:25 A.M.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>455 Ponds Wood Road  |  |   |                                 | 4b. City, Town, or Location of Death<br>Huntingtown  |  |                                      |  | 4c. County of Death<br>Calvert   |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-70-8370   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>40 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 2, 1958                                  |                                      | 9. Birthplace (State or Foreign Country)<br>Maryland             |  |  |
|  | Usual Residence of Decedent  |  |   |                                 |  |  |                                      |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Calvert  |                                 | 10c. City, Town or Location<br>Huntingtown   |  |                                      |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>455 Ponds Wood Road  |  |   |                                 | 10f. Zip Code<br>20639   |  | 10g. Citizen of What Country?<br>USA |  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |   |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer   |  |                                      | 16b. Kind of Business/Industry<br>Construction                   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Roosevelt Mackall   |  |   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br>Audrey Coby   |  |                                      |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Audrey Mackall/Mother  |  |   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>455 Ponds Wood Road Huntingtown, MD 20639   |  |                                      |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Edmonds UMC Cemetery   |  | Date<br>5/17/99                      |  | 20c. Location - City or Town, State<br>Chesapeake Beach, MD  |  |
|  | 21. Signature of Funeral Service Licensee<br>Blodgett G. Sewell  |  |   |                                 | 22. Name and Address of Facility<br>Sewell Funeral Home<br>1451 Dares Beach Road Prince Frederick, MD 20678  |  |                                      |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. SEIZURE DISORDER<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                                 |  |  |                                      |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |                                 |  |  |                                      |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |                                 |  |  |                                      |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |                                 |  |  |                                      |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CIRRHOSIS  |  |  |   |                                 |  |  |                                      |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |                                 |  |  |                                      |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |   |                                 |  |  |                                      |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                      | 28d. Describe how injury occurred                                |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                                 |  |  |                                      |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |                                 |  |  |                                      |  |  |  |
| 29b. Signature and title of certifier<br>Stephen S. Radentz, MD  |  |  |   | 29c. License number<br>O.C.M.E. |  | 29d. Date signed (Month, Day, Year)<br>May 12, 1999                                  |                                      |  |  |  |
| 30. Name and address of person who completed cause of death (Item 28e) (Type, Print)<br>Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201  |  |  |   |                                 |  |  |                                      |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 14 1999   |  | 32. Registrar's Signature<br>B. Spahr  |   |                                 |  |  |                                      |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16283

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |  |  |
|---|---|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>John Sherman McKeever   |  |   |  | 2. Date of Death<br>Month Day Year<br>May 7, 1999  |  |   |  | 3. Time of Death<br>0735   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Laurelwood Continuing Care Center   |  |   |  | 4b. City, Town, or Location of Death<br>Elkton   |  |   |  | 4c. County of Death<br>Cecil   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>219-12-9019  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>75 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>February 29, 1924                                    |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  |  | 10b. County<br>Cecil  |  | 10c. City, Town or Location<br>Conowingo   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>556 Conowingo Road  |  |   |  | 10f. Zip Code<br>21918   |  | 10g. Citizen of What Country?<br>United States  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No WWII<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter  |  |  |  | 16b. Kind of Business/Industry<br>Construction  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Samuel A. McKeever   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Belle McDardal  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary P. Barbour/ daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>556 Conowingo Road, Conowingo, Maryland 21918   |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>R.A. Ferris and Company   |  | Date<br>5/8/99   |  | 20c. Location - City or Town, State<br>West Chester, Pennsylvania                           |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Donald S. Hicks</i>   |  |   |  | 22. Name and Address of Facility<br>Hicks Home for Funerals, P.A.<br>103 West Stockton Street, Elkton, Maryland 21921  |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Chronic Obstructive Pulmonary Disease</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Coronary Artery Disease</i>  |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |   |  |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |   |  |  |  |
| State Registrar                               | 29b. Signature and title of certifier<br><i>Monte Makous, MD</i>  |  |   |  | 29c. License number<br>D-44783   |  | 29d. Date signed (Month, Day, Year)   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>MONTA MAKOUS 111 West High Street, ELKTON, MD 21921</i>  |  |   |  |  |  |   |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>MAY 11 1999  |  |   |  | 32. Registrar's Signature<br><i>Bernard D. Sparks</i>  |  |   |  |  |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3 Time of Death  
0945

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edmund Burke Miles, Jr.

2. Date of Death

May 8, 1999

Funeral  
Director

4a. Facility Name (If not in institution, give street and number)

2008 Appleton Road

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

5. Social Security Number

222-07-0843

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 16, 1921

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

2008 Appleton Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Residential Construction

17. Father's Name (First, Middle, Last)

Edmund B. Miles, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elsie Duncan

19a. Informant's Name/Relationship (Type, Print)

Dorothy Hildabrant/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34 Woodfield Court, Newark, Delaware 19713

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris and Company

Date

5/14/99

20c. Location - City or Town, State

West Chester,

Pennsylvania

21. Signature of Funeral Service Licensee

*Donald S. Hicks*

22. Name and Address of Facility

Hicks Home for Funerals, P.A.  
103 West Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☐ Nursing Home

☒ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural

☐ Pending investigation

☐ Accident

☐ Suicide

☐ Homicide

☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Karithanom Isaac*

29c. License number

D40723

29d. Date signed (Month, Day, Year)

May 10, 1999

30. Name and address of person who completed cause of death (Form 23a) (Type, Print)

KARITHANOM ISAAC, M.D., VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

MAY 11 1999

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

511VA



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16285

|  |  |   |  |   |  |                          |  |  |  |   |  |
|--|--|---|--|---|--|--------------------------|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Howard V. Pierce                         |   |  |   | 2. Date of Death<br>Month Day Year<br>May 5 1999   |                          |  |  | 3. Time of Death<br>4:20 am                          |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>1715 Principio Rd. |   |  |   | 4b. City, Town, or Location of Death<br>Rising Sun |                          |  |  | 4c. County of Death<br>Cecil                         |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-18-6778   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>76 Yrs.          |                          | 8. Date of Birth (Month, Day, Year)<br>Aug. 24, 1922   |  | 9. Birthplace (State or Foreign Country)<br>Maryland |   |  |
|  | Usual Residence of Decedent  |   |  |   | 10c. City, Town or Location<br>Rising Sun          |                          | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |   |  |
| 10e. State<br>Maryland   |  | 10b. County<br>Cecil  |  | 10f. Zip Code<br>21911  |  |                          |  | 10g. Citizen of What Country?<br>USA   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Supply Worker  |  |                          |  | 16b. Kind of Business/Industry<br>Cecil County Board of Education  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>George Pierce   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lora Abrams  |  |                          |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Ruth Ann Burton/Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1723 Principio Rd. Rising Sun, MD 21911  |  |                          |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Brookview Cemetery  |  |                          |  | 20c. Location - City or Town, State<br>Rising Sun, Maryland  |  | 20d. Date<br>5-8-99                           |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>R. T. Foard Funeral Home, P. A.<br>111 S. Queen St., Rising Sun, MD 21911   |  |                          |  |  |  |   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Metastatic Colon Cancer -<br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |  |                          |  | Approximate Interval Between Onset and Death   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |                          |  |  |  |   |  |
|  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred             |  |
|  |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br>   |  |                          |  | 29c. License number<br>D 35653   |  | 29d. Date signed (Month, Day, Year)<br>5/6/99 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Doctor Martha Hosford 111 W. High Street Elkton, MD 21921  |  |   |  | 31. Date filed (Month, Day, Year)<br>MAY 06 1999  |  |                          |  | 32. Registrar's Signature<br>  |  |   |  |

To Be Completed by Funeral Director

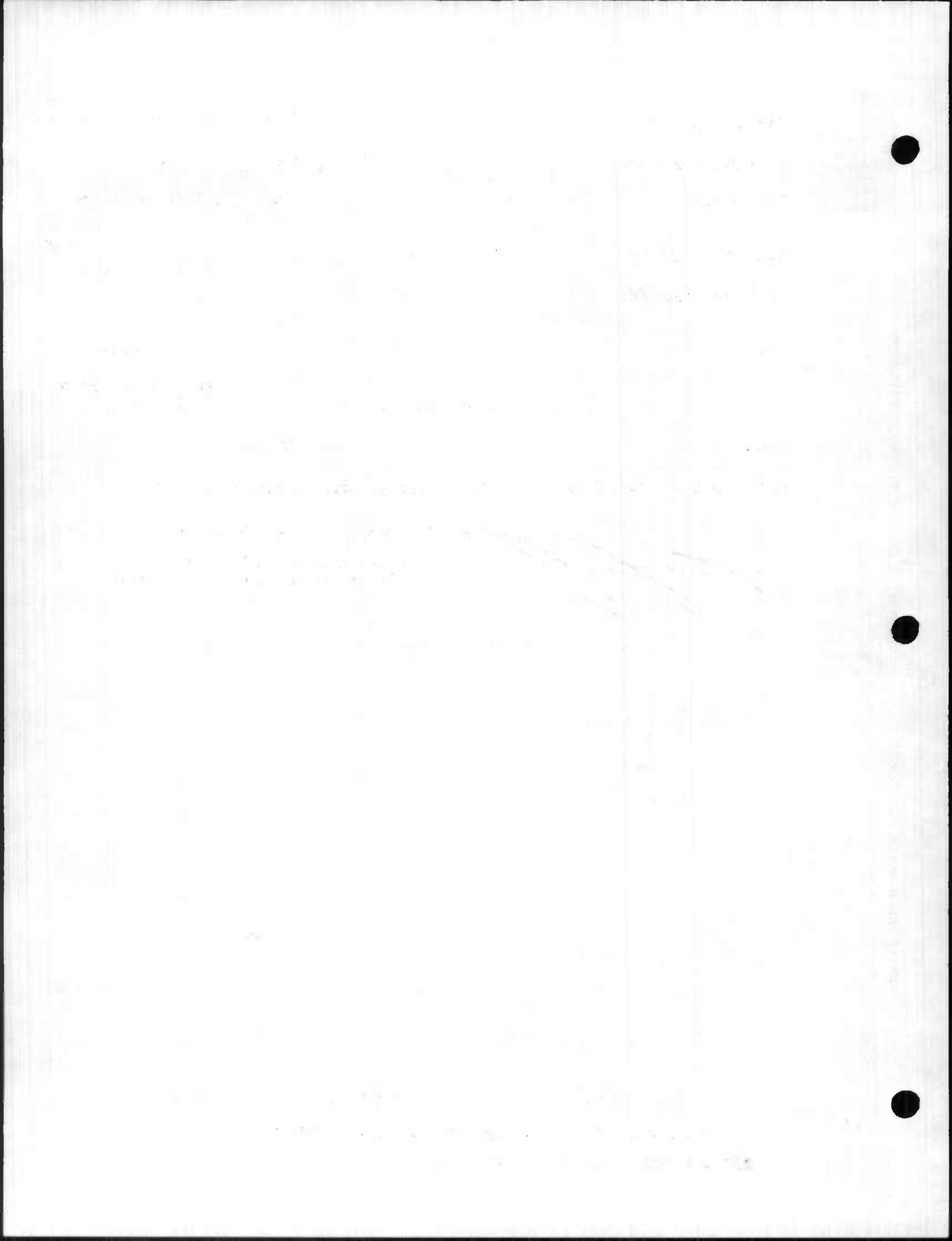
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16286

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Cleo Russell   |  |   |  | 2. Date of Death<br>May 03, 1999   |  | 3. Time of Death<br>6:15 P.M.   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>12115 Rousby Hall Road   |  |   |  | 4b. City, Town, or Location of Death<br>Lusby  |  | 4c. County of Death<br>Calvert  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>214-30-3079   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>63 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 13, 1935  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland  |  | 10b. County<br>Calvert   |  | 10c. City, Town or Location<br>Lusby  |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>12115 Rousby Hall Road  |  | 10f. Zip Code<br>20657   |  | 10g. Citizen of What Country?<br>USA  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black  |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cook                                     |  | 16b. Kind of Business/Industry<br>Restaurant   |  | 17. Father's Name (First, Middle, Last)<br>Daniel Johnson   |  |
|  | 17. Mother's Name (First, Middle, Maiden Surname)<br>Inez Gough  |  | 18. Informant's Name/Relationship (Type, Print)<br>Herbert Russell/Husband  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12115 Rousby Hall Road Lusby, MD 20657  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Herbert Russell/Husband   |  |
| To Be Completed by<br>Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Zion Hill Church Cem.   |  | 20c. Location - City or Town, State<br>Lusby, MD   |  | 20d. Date<br>5/8/99   |  |
|  | 21. Signature of Funeral Service Licensee<br>Blanche G. Sewell   |  | 22. Name and Address of Facility<br>Sewell Funeral Home<br>1451 Dares Beach Rd. Prince Frederick, MD 20678  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Sepsis Syndrome<br>Due to (or as a consequence of):<br>b. Longstanding Insulin Dependent Diabetes<br>Due to (or as a consequence of):<br>c. with multiple complications<br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death  |  |
| To Be Completed by<br>Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by<br>Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| To Be Completed by<br>Physician/Medical Examiner | 29b. Signature and title of certifier<br>Jonathan Lowenthal, M.D.  |  | 29c. License number<br>033123   |  | 29d. Date signed (Month, Day, Year)<br>5-4-99  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Jonathan Lowenthal, M.D. Prince Frederick, MD   |  |
|  | 31. Date filed (Month, Day, Year)<br>MAY 05 1999   |  | 32. Registrar's Signature<br>B. Sparks  |  |  |  |   |  |

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. The second part of the report is a detailed description of the methods used in the study. This includes a discussion of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a presentation of the results of the study. This includes a discussion of the findings and their implications for the field of study. The final part of the report is a conclusion and a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16287

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |  |   |  |
|---|--|---|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Jack Lee Ryan</b>                               |   |  |   | 2. Date of Death<br>Month Day Year<br><b>April 30, 1999</b> |  | 3. Time of Death<br><b>1:07 am</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Richey Hospice</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>    |  | 4c. County of Death<br><b>Baltimore</b>  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-72-4835</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>11/8/51</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b>                            |  |
|   | Usual Residence of Decedent  |   |  |   |   |  |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>820 N. Eutaw Street</b>  |  |   |  | 10f. Zip Code<br><b>21201</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Janitor</b>   |   |  | 16b. Kind of Business/Industry<br><b>AFL-CIO</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jack Neil Ryan</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lilith Cook</b>   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Dunning</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>150 Macrae Ave, Pr. Frederick, MD 20678</b>   |   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crem.</b>   |   | 20c. Location - City or Town, State<br><b>5/3/99 Alex., VA</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Raymond Funeral Home, P.A.<br/>P.O. Box 121, Dunkirk, MD 20754</b>   |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. END STAGE HUNTINGDON'S CHURCH</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. DEMENTIA.</b><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>YEAR</b>                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASPIRATION PNEUMONIA.</b><br><b>DEMENTIA.</b>  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HOSPICE.</b> |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. Describe how injury occurred   |   |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br><br><b>JOHN B. MACGIBBON MD</b>   |  |   |  | 29c. License number<br><b>006933</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>APRIL 30, 1999</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOHN B. MACGIBBON MD 101 WREDSI SUITE 719 BALTIMORE MD 21201</b>   |  |   |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 03 1999</b>   |  |   |  | 32. Registrar's Signature<br>   |   |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

JACK RYAN April 30, 1999 10:07 AM





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Elizabeth Josephine Reid                      |   |  |  | 2. Date of Death<br>Month Day Year<br>May 8 1999 |  | 3. Time of Death<br>12 35 AM                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Solomons Nursing Center |   |  |  | 4b. City, Town, or Location of Death<br>Solomons |  | 4c. County of Death<br>Calvert                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>404 22 9835  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>75   | If Under 1 Year<br>Months Days                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month Day Year<br>April 1924 | 9. Birthplace (State or Foreign Country)<br>Calvert  |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Calvert  |  | 10c. City, Town or Location<br>Lusby   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>3091 Calvert Blvd   |   | 10f. Zip Code<br>20657  |  | 10g. Citizen of What Country?<br>United States   |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>homemaker   |  | 16b. Kind of Business/Industry<br>own home   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Leo Fentress   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jenny Ortt  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Stewart E. Reid- husband  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 184 Lusby Maryland 20657   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery  |  | 20c. Location - City or Town, State<br>Cheltenham Maryland   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>B. Rausch  |   |   |  | 22. Name and Address of Facility<br>Rausch Funeral Home PA<br>4405 Broomes Is. Rd. Port Republic Md 20676  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |   |   |  |  |  |  |  | MORE THAN 1 YEAR   |
| a. AORTIC STENOSIS<br>Due to (or as a consequence of):  |   |   |  |  |  |  |  | MORE THAN 1 YEAR   |
| b. ATHEROSCLEROSIS<br>Due to (or as a consequence of):  |   |   |  |  |  |  |  |  |
| c.<br>Due to (or as a consequence of):  |   |   |  |  |  |  |  |  |
| d.<br>Due to (or as a consequence of):  |   |   |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |  |  |  |
| ATRIAL FIBRILLATION.  |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| CONGESTIVE HEART FAILURE  |   |   |  |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
| DEMENTIA  |   |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Gyan C. Surana   |   |   |  | 29c. License number<br>D-50653   |  | 29d. Date signed (Month, Day, Year)<br>05-10-1999  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>GYAN C. SURANA<br>5851. DEALE CHURCHTON ROAD DEALE M.D. 20751   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 11 1999  |   | 32. Registrar's Signature<br>B. Sparks  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

39 16289

|  |   |   |  |  |   |  |   |  |
|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SHIRLEY MAE RICHMAN</b>                                  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MAY 10, 1999</b> |  | 3. Time of Death<br><b>7:15 A.M.</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GENESIS ELDERCARE NURSING HOME</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>LA PLATA</b>   |  | 4c. County of Death<br><b>CHARLES</b>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-28-7426</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 16, 1930</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>WISCONSIN</b>  |   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>CHARLES</b>                             |  | 10c. City, Town or Location<br><b>LA PLATA</b>              |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>1 MAGNOLIA DRIVE</b>   |  | 10f. Zip Code<br><b>20646</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>Collage (1-4 or 5+)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>RAYMOND ZENTZ</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIOLET BEUSHEAR</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DEBRA L. WILSON - NIECE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2061 HYDE COURT WALDORF, MARYLAND 20601</b>  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>   |  | 20c. Date<br><b>5-11-99</b>  |   | 20d. Location - City or Town, State<br><b>ALEXANDRIA, VA.</b>                        |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael O. L...</i>  |   |   |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A.<br/>LA PLATA, MARYLAND 20646</b>  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Sclerosis</b><br>Due to (or as a consequence of):<br><b>b. Hypertension</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>20+ yr.</b><br><b>16+ yr.</b> |   |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |  |  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |   |  |   |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   | 29c. License number<br><b>120629</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/10/99</b>  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GROVER W. WATSON WALDORF, MD 20603</b>  |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 1999</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN ELIZABETH SMITH

2. Date of Death

Month Day Year  
MAY 4, 1999

3. Time of Death

10:42 pm

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

5. Social Security Number

135 01 9494

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 21, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Charlotte Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

Route # 2, Box 5

10f. Zip Code

20622

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerical Worker

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

James

Smith

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth

McDougall

19e. Informant's Name/Relationship (Type, Print)

Robert Henry Hyers/Great Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

584A Pinewood Drive, Annapolis, MD 21401

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

5/6/99

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

Charles F. Bell

22. Name and Address of Facility

Rausch Funeral Home, P.A.

P.O. Box 100, Owings, MD 20736

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CARCINOMA OF VULVA

Due to (or as a consequence of):

b. UNDIFFERENTIATED CARCINOMA

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death  
MORE THAN 1 YEAR

MORE THAN 1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

DECUBITUS ULCERS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gyan Chand Surana

29c. License number

D 50653

29d. Date signed (Month, Day, Year)

5-5-1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GYAN CHAND SURANA  
5851 DEALE CHURCHTON ROAD DEALE M.D. 20751

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



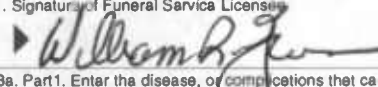


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

|   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LOUIS ARNOLD SMITH</b>                              |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MAY 1, 1999</b>                |  | 3. Time of Death<br><b>1027</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick Calvert</b> |  | 4c. County of Death  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579 09 8489</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Mar 17, 1920</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                             |  |
|   | Usual Residence of Decedent  |   |  |  |   |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>St. Leonard</b>  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>1540 Woods Road</b>  |  |   |  | 10f. Zip Code<br><b>20685</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944-46</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                            |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>salesman</b>   |   |  | 16b. Kind of Business/Industry<br><b>wholesale</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Smith</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertha Burke</b>   |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Teresa L. Jeschelnik, daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1560 Sycamore Lane, Port Republic, MD 20676</b>  |   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>So. Memorial Gardens</b>   |  | Date<br><b>5-5-99</b>  |   | 20c. Location - City or Town, State<br><b>Dunkirk, MD</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A., Owings, MD 20736</b>   |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Urosepsis - Septic Shock</b><br>Due to (or as a consequence of):<br><br>b. <b>Acute Myocardial Infarction - cardiogenic shock</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><br><b>2 days</b><br><br><b>2 hours</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Abdominal Aortic Aneurysm</b><br><b>Obstructive Prostatic Uropathy</b>   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Gerald P. Sterner M.D.</b>  |  | 29c. License number<br><b>D 17245</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 1, 1999</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Gerald P. Sterner, M.D., Owings, Maryland 20736</b>  |  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 05 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Marguerite C. Stack  |   | 2. Date of Death<br>Month Day Year<br>April 30, 1999  |  | 3. Time of Death<br>10:30PM  |
|   | 4e. Facility Name (If not institution, give street and number)<br>Gladys Spellman Nursing Center   |   | 4b. City, Town, or Location of Death<br>Cheverly  |  | 4c. County of Death<br>Prince George's   |
| Funeral<br>Director   | 5. Social Security Number<br>578-54-8031   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>89 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>July 13, 1909 | 9. Birthplace (State or Foreign Country)<br>Maryland   |
|   | Usual Residence of Decedent  |   |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Prince George's  | 10c. City, Town or Location<br>Capitol Heights  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br>5514 Walker Mill Road  |   | 10f. Zip Code<br>20743  |  | 10g. Citizen of What Country?<br>U.S.A.  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th College (1-4 or 5+) N/A                            |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>School Bus Driver   |   | 16b. Kind of Business/Industry<br>Prince George's Co. Schools   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Frederick Stack   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Sauberlich  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Paul A. Kasulke (Brother-in-law)   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5514 Walker Mill Road Capitol Heights MD 20743       |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Epiphany Episcopal Church Cem.  |  | 20c. Location - City or Town, State<br>Forestville, Maryland   |
|   | 21. Signature of Funeral Service Licensee<br>Charles L. Belanger   |   | 22. Name and Address of Facility<br>Lee Funeral Home, Inc.<br>6633 Old Alexandria Ferry Rd Clinton, MD 20735  |  |  |
|   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE years<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |
| Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.<br>Cerebral Infarction Vascular Dementia<br>Deep vein Thrombosis<br>Sacral Decubitus   |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |
| 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                             |  |
| 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br>Paul A. DeVore   |  | 29c. License number<br>D 01852  |   | 29d. Date signed (Month, Day, Year)<br>MAY 1, 1999   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20782   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 04 1999  |  | 32. Registrar's Signature<br>B. Sparks  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16293

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Alverson Sewell

2. Date of Death

April 27, 1999

3. Time of Death

3:55 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

8100 Connecticut Ave Apt 511

4b. City, Town, or Location of Death

Chevey Chase

4c. County of Death

Montgomery

5. Social Security Number

220 44- 7511

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec 24, 1901

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevey Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8100 Connecticut Ave Apt 511

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

John Lee Alverson

18. Mother's Name (First, Middle, Maiden Surname)

Maude Muller Marshall

19a. Informant's Name/Relationship (Type, Print)

Michael K. Furey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

932 Hungerford Drive Suite 13, Rockville, Md 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory April 27, 1999

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of the Colon with Sigmoid Metastases 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. Neil Kennedy, MD

29c. License number

00013187

29d. Date signed (Month, Day, Year)

4/27/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mr. Neil Kennedy, MD 5530 Wisconsin Ave Suite 240, Chevy Chase, Md 20815

31. Date filed (Month, Day, Year)

APR 29 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |  |
|--|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT CHARLES SCHOBER</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>MAY 1, 1999</b>   |   | 3. Time of Death<br><b>1225pm</b>                              |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick, Calvert</b>   |   | 4c. County of Death<br><b>Calvert</b>                          |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>361 12 3012</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |   | 8. Date of Birth<br>Month Day Year<br><b>Dec. 22, 1925</b>     |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Calvert</b>  |   | 10c. City, Town or Location<br><b>Solomons</b>                 |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>13325 Dowell Road</b>  |  | 10f. Zip Code<br><b>20688</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>          |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1944</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br><b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>                                |  | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Robert Samuel Schober</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Domitilla Mulloy</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean M. McConachie/ sister</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12634 Santa Rosa Circle, Lusby, MD 20657</b>   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>5/2/99</b>  |   | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Charles F. Bell Jr.</b>  |   | 22. Name and Address of Facility<br><b>Rausch Funeral Home, P.A.<br/>4405 Broomes Island Road, Port Republic, MD 20676</b>                                    |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>s. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>COPD</b><br>Due to (or as a consequence of):<br>c. <b>CHF</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  |
|  | Approximate Interval Between Onset and Death<br><b>4 days</b>  |   |   |  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Kimberly D. Larsen</b>  |   | 29c. License number<br><b>D51722 MD</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/2/99</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Kimberly D. Larsen, M.D. Prince Frederick, MD. 20678</b>  |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 03 1999</b>  |  | 32. Registrar's Signature<br><b>Geneva B. Spawth</b>  |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 69760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16295

|   |  |  |                                   |  |  |  |   |  |
|---|--|--|-----------------------------------|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Mark Anthony Steinmann   |  |                                   |  | 2. Date of Death<br>Month Day Year<br>APRIL 28, 1999   |  | 3. Time of Death<br>1150  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>8106 ALEXANDER FERRY RD #2   |  |                                   |  | 4b. City, Town, or Location of Death<br>CLINTON  |  | 4c. County of Death<br>PRINCE GEORGES   |  |
| Funeral<br>Director   | 5. Social Security Number<br>143 32 2294   |  | 6. Sex<br>XX M 20 F               |  | 7. Age (In yrs. last birthday)<br>56 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb 4, 1943  |  |
|   | 9. Birthplace (State or Country)<br>New York, New  |  | 10a. State<br>MD                  |  | 10b. County<br>P.G.  |  | 10c. City, Town or Location<br>Clinton  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>10 Yes 20 No  |  |                                   |  | 10e. Street and Number<br>8106 Alexander Ferry Road #2   |  | 10f. Zip Code<br>20735  |  |
|   | 10g. Citizen of What Country?<br>United States   |  |                                   |  | 11. Marital Status<br>10 Never Married 20 Married<br>30 Widowed 40 Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>XX Yes 20 No<br>If Yes, Give Year or Dates:                                |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>10 Yes 20 No Specify:  |  |                                   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>12 3 |  |
|   | 16. Kind of Business/Industry<br>Boeing Aircraft   |  |                                   |  | 17. Father's Name (First, Middle, Last)<br>Elmer R. Steinmann  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Henrietta M. Kogel   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>(DAUGHTER & SON IN LAW)<br>Teresa & Donald Evans   |  |                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>109 C River Point Drive, Destrehan, Louisiana 70047 |  |   |  |
|   | 20a. Method of Disposition<br>XX Burial 20 Cremation 30 Removal from State<br>40 Donation 50 Other (Specify)   |  |                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>May 5, 1999<br>Jefferson Memorial Gardens                                  |  | 20c. Location - City or Town, State<br>St. Rose, Louisiana  |  |
|   | 21. Signature of Funeral Service Licensee<br>St. S. Smith  |  |                                   |  | 22. Name and Address of Facility<br>Lee Funeral Home, Inc 6633 Old<br>Alexandria Ferry Road, Clinton, Maryland 20735                                 |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |                                   |  |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>10 Yes 20 No 30 Probably 40 Unknown  |  |                                   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>10 Yes 20 No  |  |  |                                   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>10 Yes 20 No |  |  |                                   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br>10 Yes 20 No   |  |                                   |  | 26. Place of Death (Check only one)<br>Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify)         |  |   |  |
|   | 27. Manner of Death<br>10 Natural 50 Pending investigation<br>20 Accident 60 Could not be determined<br>30 Suicide 40 Homicide   |  |                                   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  |
|   | 28c. Injury at Work?<br>10 Yes 20 No   |  | 28d. Describe how Injury occurred |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|   | 29a. Certifier (Check only one)<br>10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                   |  |  |  |   |  |
| State<br>Registrar  | 29b. Signature and title of certifier<br>Mario F. Gole, MD   |  |                                   |  | 29c. License number<br>D33954  |  | 29d. Date signed (Month, Day, Year)<br>APRIL 29, 1999   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MARIO F. GOLE, MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785  |  |                                   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 04 1999  |  |  |                                   | 32. Registrar's Signature<br>G. Sparks |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deleted for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 16296

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Elise Margaret Swavely</b>   |  | 2. Date of Death<br>Month <b>May</b> Day <b>4</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>2208</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Union Hospital</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Elkton</b>                              |  | 4c. County of Death<br><b>Cecil</b>  |
| 5. Social Security Number<br><b>196-24-0041</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>December 20, 1914</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |   |  |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Cecil</b>  | 10c. City, Town or Location<br><b>North East</b>  |  |  |  |
| 10e. Street and Number<br><b>519 Trinity Church Road</b>  |  | 10f. Zip Code<br><b>21901</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>In her own home</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Oscar Appenzeller</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lena Louisa Rebrassier</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda J. Tomasulo/daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>519 Trinity Church Road, North East, Maryland 21901</b>   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>R.A. Ferris and Company</b>  |  | 20c. Location - City or Town, State<br><b>West Chester, Pennsylvania</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Donna S. Hicks</b>  |  | 22. Name and Address of Facility<br><b>Hicks Home for Funerals, P.A.<br/>103 West Stockton Street, Elkton, Maryland 21921</b>   |  |  |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Acute Respiratory Distress Syndrome</b><br>Due to (or as a consequence of):<br><br>b. <b>Respiratory Failure</b><br>Due to (or as a consequence of):<br><br>c. <b>Pneumococcal Pneumonia</b><br>Due to (or as a consequence of):<br><br>d. |  |   |  |  | Approximate Interval Between Onset and Death<br><br><b>2 weeks</b><br><br><b>2 weeks</b><br><br><b>2 1/2 weeks</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Hypothyroidism Depression / Anxiety</b><br><b>Hypertension Head &amp; Neck Cancer</b>  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Worcher JWW</b>   |  | 29c. License number<br><b>044373</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>May 5, 1999</b>   |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>101 Colonial Way Rm 501 MD 21911</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>   |  | 32. Registrar's Signature<br><b>P. Sparks</b>   |  |  |  |

1.      2.      3.      4.      5.      6.      7.      8.      9.      10.      11.      12.      13.      14.      15.      16.      17.      18.      19.      20.      21.      22.      23.      24.      25.      26.      27.      28.      29.      30.      31.      32.      33.      34.      35.      36.      37.      38.      39.      40.      41.      42.      43.      44.      45.      46.      47.      48.      49.      50.      51.      52.      53.      54.      55.      56.      57.      58.      59.      60.      61.      62.      63.      64.      65.      66.      67.      68.      69.      70.      71.      72.      73.      74.      75.      76.      77.      78.      79.      80.      81.      82.      83.      84.      85.      86.      87.      88.      89.      90.      91.      92.      93.      94.      95.      96.      97.      98.      99.      100.

101.      102.      103.      104.      105.      106.      107.      108.      109.      110.      111.      112.      113.      114.      115.      116.      117.      118.      119.      120.      121.      122.      123.      124.      125.      126.      127.      128.      129.      130.      131.      132.      133.      134.      135.      136.      137.      138.      139.      140.      141.      142.      143.      144.      145.      146.      147.      148.      149.      150.      151.      152.      153.      154.      155.      156.      157.      158.      159.      160.      161.      162.      163.      164.      165.      166.      167.      168.      169.      170.      171.      172.      173.      174.      175.      176.      177.      178.      179.      180.      181.      182.      183.      184.      185.      186.      187.      188.      189.      190.      191.      192.      193.      194.      195.      196.      197.      198.      199.      200.

201.      202.      203.      204.      205.      206.      207.      208.      209.      210.      211.      212.      213.      214.      215.      216.      217.      218.      219.      220.      221.      222.      223.      224.      225.      226.      227.      228.      229.      230.      231.      232.      233.      234.      235.      236.      237.      238.      239.      240.      241.      242.      243.      244.      245.      246.      247.      248.      249.      250.      251.      252.      253.      254.      255.      256.      257.      258.      259.      260.      261.      262.      263.      264.      265.      266.      267.      268.      269.      270.      271.      272.      273.      274.      275.      276.      277.      278.      279.      280.      281.      282.      283.      284.      285.      286.      287.      288.      289.      290.      291.      292.      293.      294.      295.      296.      297.      298.      299.      300.

301.      302.      303.      304.      305.      306.      307.      308.      309.      310.      311.      312.      313.      314.      315.      316.      317.      318.      319.      320.      321.      322.      323.      324.      325.      326.      327.      328.      329.      330.      331.      332.      333.      334.      335.      336.      337.      338.      339.      340.      341.      342.      343.      344.      345.      346.      347.      348.      349.      350.      351.      352.      353.      354.      355.      356.      357.      358.      359.      360.      361.      362.      363.      364.      365.      366.      367.      368.      369.      370.      371.      372.      373.      374.      375.      376.      377.      378.      379.      380.      381.      382.      383.      384.      385.      386.      387.      388.      389.      390.      391.      392.      393.      394.      395.      396.      397.      398.      399.      400.

401.      402.      403.      404.      405.      406.      407.      408.      409.      410.      411.      412.      413.      414.      415.      416.      417.      418.      419.      420.      421.      422.      423.      424.      425.      426.      427.      428.      429.      430.      431.      432.      433.      434.      435.      436.      437.      438.      439.      440.      441.      442.      443.      444.      445.      446.      447.      448.      449.      450.      451.      452.      453.      454.      455.      456.      457.      458.      459.      460.      461.      462.      463.      464.      465.      466.      467.      468.      469.      470.      471.      472.      473.      474.      475.      476.      477.      478.      479.      480.      481.      482.      483.      484.      485.      486.      487.      488.      489.      490.      491.      492.      493.      494.      495.      496.      497.      498.      499.      500.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16297

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alvina Irene Snowberger

2. Date of Death

May 1, 1999

3. Time of Death

13128

4a. Facility Name (If not institution, give street and number)

52 Providence Rd.,

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

218-36-6290

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

December 2, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

52 Providence Road

10f. Zip Code

21921

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Warehouse worker

16b. Kind of Business/Industry

Pice i Imports

17. Father's Name (First, Middle, Last)

Thomas

18. Mother's Name (First, Middle, Maiden Surname)

No Information Available

19a. Informant's Name/Relationship (Type, Print)

Harry Snowberger- husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

52 Providence Road, Elkton, Md. 21921

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. FERRIS &amp; Co.

Date

May 3, 1999

20c. Location - City or Town, State

West Chester, Pa.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Gee Funeral Home  
259 E. Main St., Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CVA  
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months  
years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MI, IDDM, HBP, A fib

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] W. Farkas, MD

29c. License number

D15314

29d. Date signed (Month, Day, Year)

May 4, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W. Farkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD

31. Date filed (Month, Day, Year)

MAY 05 1999

32. Registrar's Signature

[Signature] B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16298

|  |  |  |  |   |  |   |   |  |
|--|--|--|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELI JOSE TORRES</b>   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>May 2 1999</b>  |   | 3. Time of Death<br><b>6:00 A.M.</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Mariner Health of Southern Maryland</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |   | 4c. County of Death<br><b>Prince George's</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-48-1997</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 22, 1912</b>   | 9. Birthplace (State or Foreign Country)<br><b>Canada</b>                        |
|  | Usual Residence of Decedent  |  |  |   | 10e. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 10e. Street and Number<br><b>9211 Sturat Lane</b>  |   | 10f. Zip Code<br><b>20735</b>   |  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steno - Typist</b>   |   | 16b. Kind of Business/Industry<br><b>Columbia Reporting Co.</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Jose Torres</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marconi Angelina</b>   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Sherlene G. Williams (Friend)</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9425 Hale Drive Clinton, Maryland</b>  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |  |   | 22. Name and Address of Facility<br><b>Lee Funeral Home, Inc.<br/>6633 Old Alexandria Ferry Road Clinton, MD 20735</b>   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. VENTRICULAR ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   | Approximate Interval Between Onset and Death<br><b>10 MINUTE</b><br><b>MORE THAN 1 YEAR</b>  |   |   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS.</b><br><b>CONGESTIVE HEART FAILURE</b>   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                             |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |
| 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D 50653</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 03 - 1999</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>5851 DEALE CHURCHTON ROAD. DEALE M.D. 20751.</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>   |  |   |   |  |
| 32. Registrar's Signature<br>  |  |  |  |   |  |   |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16299

|  |   |  |   |  |  |  |   |   |  |  |
|--|---|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CLARENCE A. WALKER</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>29</b> Year <b>1999</b>  |  |   |   | 3. Time of Death<br><b>12:35 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>OLNEY</b>   |  |   |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-14-7394</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 10, 1910</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Olney</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>17532 Georgia Avenue</b>   |  |   |  | 10f. Zip Code<br><b>20832</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodian</b>                     |  | 16b. Kind of Business/Industry<br><b>Montg. Co. Schools</b>  |  |   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Alfred Walker</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Pumphrey</b>   |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>Christine Walker (Daughter)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17532 Georgia Ave., Olney, MD 20832</b>  |  |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Church Cem.</b>   |  | Date<br><b>5/5/99</b>  |  | 20c. Location - City or Town, State<br><b>Gaithersburg, MD</b>  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>George R. Browder</i>   |  |   |  | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>  |  |   |   |  |  |
|  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Acute renal failure</b><br>Due to (or as a consequence of):<br>b. <b>Chronic renal failure</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>d. |  |   |  |  |  |   |   |  |  |
|  | 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>{  |  |   |  |  |  |   |   |  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>Dennis M. Hannon MD</i>   |  | 29c. License number<br><b>023124</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 29, 1999</b>  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DENNIS M. HANNON MD 1396 PILLARD DRIVE; ROCKVILLE, MD 20850</b>  |  |   |  |  |  |   |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |   |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

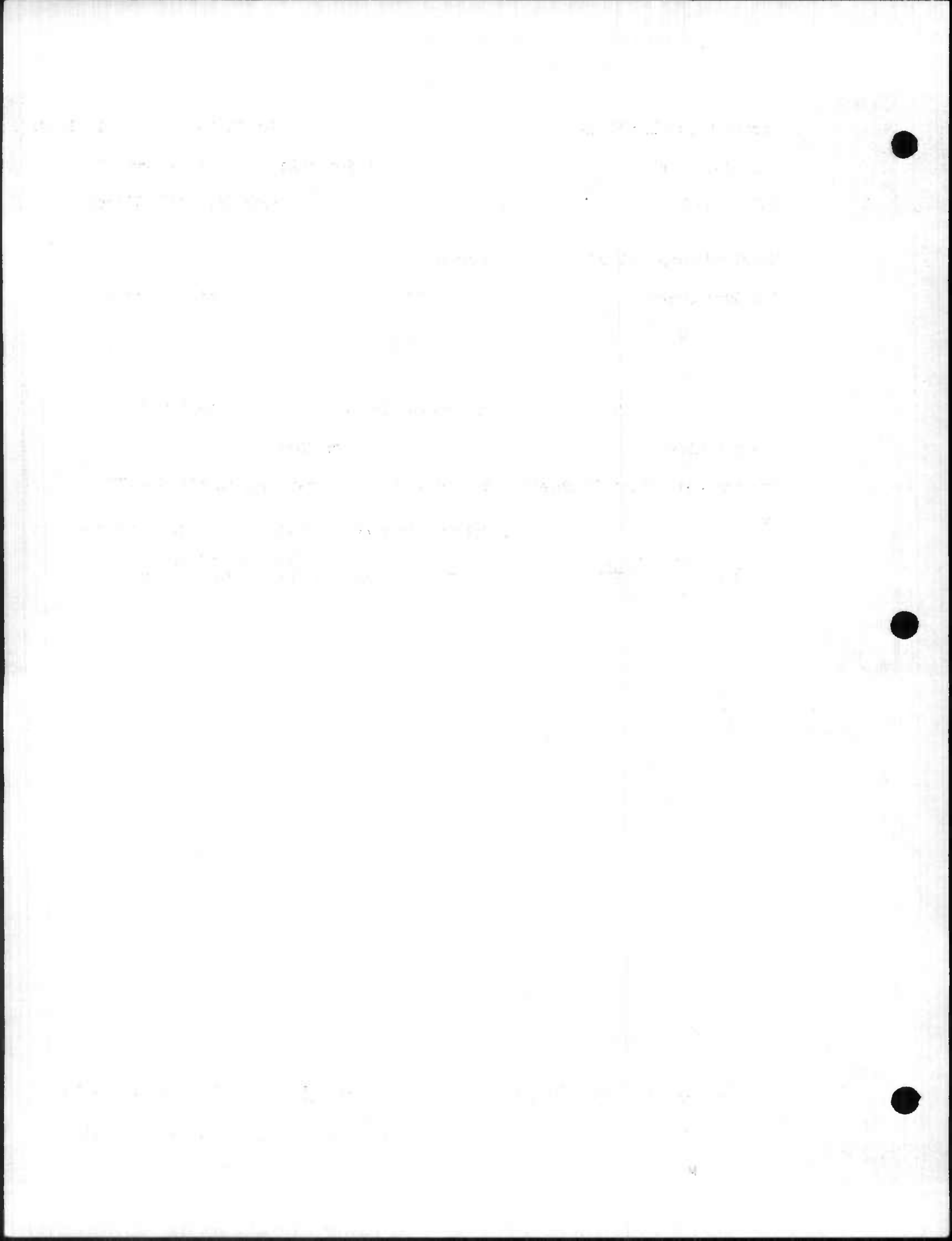
Reg. No.

|  |   |   |  |   |   |  |  |  |
|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Lucille Vance</b>               |   |  |   | 2. Date of Death<br>Month <b>May</b> 7, 1999 Year         |  | 3. Time of Death<br><b>10:15 P.M.</b>                        |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>469 Avon Court</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Friendship</b> |  | 4c. County of Death<br><b>Anne Arundel</b>                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>353-44-3862</b>   |   | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.  | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 10, 1948</b> | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>  |
|  | Usual Residence of Decedent   |   |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Friendship</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br><b>469 Avon Court</b>  |   |   |  | 10f. Zip Code<br><b>20758</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>  |   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>  |   | 16b. Kind of Business/Industry<br><b>Health Care</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Simon Boulds</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Rice</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stephan Dean Vance (husband)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>469 Avon Court, Friendship, Maryland 20758</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Calvary Cemetery 5-10-99</b>   |  | Date  |   | 20c. Location - City or Town, State<br><b>Lothian, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>SK F. Smith</b>  |   |   |  | 22. Name and Address of Facility<br><b>Lee Funeral Home, P.A.<br/>8125 Southern MD Blvd; Owings, MD 20736</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>ovarian cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>1 1/2 years</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|  |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>George A. Sorios MD</b>  |   |   |  | 29c. License number<br><b>D43083</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 9, 1999</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GEORGE A. SORIOS, MD 9707 Medical Center Drive #300 Rockville, MD 20850</b>   |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 1999</b>  |   |   |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16301

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Yue Man Yee

2. Date of Death

Month

Day

Year

Apr 30 1999

3. Time of Death

1845

4a. Facility Name (If not institution, give street and number)

2300 Eccleston Rd.

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577 78 9807

6. Sex

M

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month

Day

Year

Sept 10, 1927

9. Birthplace (State or Foreign Country)

Canton, China

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2300 Eccleston Street

10f. Zip Code

20902

10g. Citizen of What Country?

China

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Oriental

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Chef

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Joseph Hong Yee

18. Mother's Name (First, Middle, Maiden Surname)

Fee Wah Chung

19a. Informant's Name/Relationship (Type, Print)

John C. Yee (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2300 Eccleston Street, Silver Spring, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

George Washington Cemetery

Date

20c. Location - City or Town, State

Adelphi, Maryland

21. Signature of Funeral Service Licensee

Charles L. Belanger

22. Name and Address of Facility

Lee Funeral Home, Inc 6633 Old

Alexandria Ferry Road, Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory insufficiency

Due to (or as a consequence of):

b. Emphysema

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DME

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Brecher M DME

29c. License number

D00428

29d. Date signed (Month, Day, Year)

Apr 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRA N BRECHER, MD DME

2101 medical Park Dr

Silver Spring MD 20902

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

B. Spahn

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16302

|  |   |  |  |  |  |  |  |   |  |  |
|--|---|--|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Benton ANTHONY</b>   |  |  |  |  |  | 2. Date of Death<br>Month <b>5</b> Day <b>19</b> Year <b>99</b>  |   | 3. Time of Death<br><b>10:50 A.M.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Richey House</b>  |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-40-7529</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>10-24-43</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>West Va</b>   |  |
|  | Usual Residence of Decedent   |  |  |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><b>8 N. Morley Street</b>   |  |  |  | 10f. Zip Code<br><b>21229</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th grade</b> College (1-4 or 5+) <b>NA</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>laborer</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Construction Co</b>   |   |  |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>Benton Anthony, Jr</b>  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice Katherine White</b>   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bette J. Spivery Sister</b>  |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 Bolton Hill Apt 217 Balto, Md 21201</b> |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>   |  |  |  | Date<br><b>5-24-99</b>   |   | 20c. Location - City or Town, State<br><b>Arbutus, Md</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Bladys women</b>  |  |  |  |  |  | 22. Name and Address of Facility<br><b>March F. H. West 4300 Wabash Avenue Balto, Md 21215</b>   |   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Terminal respiratory failure</b><br>Due to (or as a consequence of):<br><b>b. Squamous cell carcinoma of (R) lung with metastases</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>Hours</b><br><b>4 months</b>  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, secondary to (b), in partial remission</b>   |  |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |  |  |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |  |  |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>Dr. B. J. ... M.D.</b>   |  |  |  | 29c. License number<br><b>DO2175</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5-19-99</b>  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rolfe B. FENN</b>  |  |  |  |  |  | <b>8824 Winands Road Randallstown, MD 21133</b>  |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  | 32. Registrar's Signature<br><b>B. Sparks</b>  |  |  |  |  |   |  |  |

2011-12-19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16303

|   |   |                          |   |   |   |  |  |  |   |  |  |
|---|---|--------------------------|---|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Katherine T Booker</u>   |                          |   |   | 2. Date of Death<br>Month <u>May</u> Day <u>18</u> Year <u>1999</u> |  |  |  | 3. Time of Death<br><u>1:22 pm</u>                                      |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>University of Maryland - Shock Trauma Ctr. Baltimore</u> |                          |   |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>            |  |  |  | 4c. County of Death<br><u>Baltimore City</u>                            |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>212-34-7078</u>   |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><u>90</u> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><u>05-09-09</u> |  | 9. Birthplace (State or Foreign Country)<br><u>VA</u>                   |  |  |
|   | Usual Residence of Decedent   |                          |   |   |   |  |  |  |   |  |  |
| 10a. State<br><u>MD</u>   |   | 10b. County<br><u>NA</u> |   | 10c. City, Town or Location<br><u>Baltimore</u>   |   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No           |   |  |  |
| 10e. Street and Number<br><u>4107 Barrington Road</u>   |   |                          |   | 10f. Zip Code<br><u>21207</u>   |   |  |  | 10g. Citizen of What Country?<br><u>USA</u>  |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>9th grade</u> College (1-4 or 5+) <u>NA</u>   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Domestic</u>  |   |  |  | 16b. Kind of Business/Industry<br><u>various trades</u>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Joseph A. Willis</u>  |   |                          |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Rebecca Lewis</u>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Robert Byrd</u>  |   |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>4107 Barrington Road Baltimore, MD. 21207</u>   |   |  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>MD. Nat'l Mem.Pk. Cem. 05-24-99 Laurel, MD</u>   |   |  |  | 20c. Location - City or Town, State  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |   |                          |   | 22. Name and Address of Facility <u>Baltimore, Maryland 21202</u><br><u>WM.C.March FH 1101 E. North Avenue</u>  |   |  |  |  |   |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                          |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Cardiopulmonary arrest</u><br>Due to (or as a consequence of):<br>b. <u>Subdural Hemorrhage</u><br>Due to (or as a consequence of):<br>c. <u>Fall to ground</u><br>Due to (or as a consequence of):<br>d.  |   |                          |   |   |   |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                          |   |   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|   |   |                          |   |   |   |  |  |  |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |   |                          |   |   |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                          |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                          |   | 28a. Date of Injury (Month, Day, Year)<br><u>May 17 1999</u>  |   | 28b. Time of Injury<br><u>unk a M</u>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No            |   | 28d. Describe how injury occurred<br><u>Patient Fell down.</u>   |  |
|   |   |                          |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u>Home</u>   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u>4107 Barrington Rd.</u> |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                          |   | 29b. Signature and title of certifier<br><u>[Signature]</u>   |   |  |  | 29c. License number<br><u>P10077</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>May 18 1999</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Kerry Kole 22 S. Greene St. Baltimore MD</u>   |   |                          |   |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>MAY 21 1999</u>   |   |                          |   | 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar  
 DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16304

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA M. BRAUN

2. Date of Death

May 18 1999

3. Time of Death

3:35 AM

4a. Facility Name (If not institution, give street and number)

ST. ELIZABETH REHABILITATION & NURSING CTR

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-64-6115

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth

1 ☐ Under 1 Year 2 ☐ Under 24 Hrs. 3 ☐ Under 24 Hrs. 4 ☐ Under 24 Hrs.

8. Date of Birth (Month, Day, Year)

AUG 27, 1907

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1316 BROOK ROAD

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FRANCIS HARANT

18. Mother's Name (First, Middle, Maiden Surname)

MONICA BEZVADA

19a. Informant's Name/Relationship (Type, Print)

PATRICIA L. BRAUN

(DAUGHTER-IN-LAW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1316 BROOK ROAD - BALTIMORE, MARYLAND 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

5/21/99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Quanta R Thomas

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.

4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Chronic heart failure

4 months

Due to (or as a consequence of):

b. Coronary artery disease

10 years

Due to (or as a consequence of):

c. Chronic atrial fibrillation

1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Yelena Lipnik MD

29c. License number

00052746

29d. Date signed (Month, Day, Year)

May 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yelena Lipnik, 720 Maiden Choice Lane Balto 21228

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

Yelena Lipnik

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

BRAUN, CLARA

AA4





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16305

|   |   |                                 |   |   |  |   |  |   |
|---|---|---------------------------------|---|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>James B. Bull Jr.</u>                                    |                                 |   |   | 2. Date of Death<br>Month <u>May</u> Day <u>20</u> Year <u>1999</u>  |   | 3. Time of Death<br><u>11:35am</u>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Johns Hopkins Bayview Med Ctr.</u> |                                 |   |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |   | 4c. County of Death<br><u>Baltimore</u>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><u>212-44-4266</u>   |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>53</u> Yrs.  | If Under 1 Year<br>Months _____ Days _____   | If Under 24 Hrs.<br>Hours _____ Min. _____  | 8. Date of Birth (Month, Day, Year)<br><u>5/10/1946</u>  | 9. Birthplace (State or Foreign Country)<br><u>MARYLAND</u>   |
|   | Usual Residence of Decedent   |                                 |   |   |  |   |  |   |
| 10a. State<br><u>MARYLAND</u>   |   | 10b. County<br><u>BALTIMORE</u> |   | 10c. City, Town or Location<br><u>BALTIMORE</u>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><u>4670 PARK HEIGHTS AVE.</u>   |   |                                 |   | 10f. Zip Code<br><u>21215</u>   |  | 10g. Citizen of What Country?<br><u>U.S.A</u>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>BLACK</u>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) _____  |   |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>LABORER</u> |  |   | 16b. Kind of Business/Industry<br><u>College</u>   |   |
| 17. Father's Name (First, Middle, Last)<br><u>JAMES BOBBY BULL SR.</u>  |   |                                 |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>PEARL IDA PRINGLE</u>  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>BARBARA SPELL / Sister</u>   |   |                                 |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2113 CRIMEAR RD. APT A2 BALTIMORE, MD. 21207</u>   |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Mt. Zion Cemetery</u>  |   | Date<br><u>5/26/99</u>   |   | 20c. Location - City or Town, State<br><u>Landsdowne, Maryland</u>                             |   |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |   |                                 |   |   | 22. Name and Address of Facility<br><u>THE DERRICK C JONES FUNERAL HOME, 4611 PARK HEIGHTS AVE. BALTIMORE, MARYLAND 21215</u>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>aspiration pneumonia</u><br>Due to (or as a consequence of):<br><br>b. <u>cranial nerve dysfunction</u><br>Due to (or as a consequence of):<br><br>c. <u>multiple CVA's</u><br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                                 |   |   |  |   |  | Approximate Interval Between Onset and Death<br><br><u>2 weeks</u><br><br><u>6 months</u><br><br><u>5 years</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>retroviral infection</u>   |   |                                 |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                 |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |                                 | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M _____   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                 | 28d. Describe how injury occurred   |   |  |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                 | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                                 |   |   |  |   |  |   |
| 29b. Signature and title of certifier<br><u>P. Barditch MD</u>  |   |                                 |   |   | 29c. License number<br><u>D35701</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>5/20/99</u>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>P. BARDITCH 4940 EASTERN AVE. BALTIMORE, MARYLAND 21234</u>  |   |                                 |   |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><u>MAY 21 1999</u>   |   |                                 | 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER H. BARNETT

2. Date of Death

5-18-99

Day Year

3. Time of Death

9:35

4a. Facility Name (If not institution, give street and number)

(HOME) 3903 N. ROGER AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

226-07-5639

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11-22-17

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3903 N. ROGER AVE.

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABOR

16b. Kind of Business/Industry

LONGSHOREMAN

17. Father's Name (First, Middle, Last)

HARPER BARNETT

18. Mother's Name (First, Middle, Maiden Sumama)

ANNIE DAVIS

19a. Informant's Name/Relationship (Type, Print)

ROCELLIE PHILLIPS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3903 N. ROGER AVE. BALTIMORE MARYLAND 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

5-24-99

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Carl A. Step

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.

1300 EUTAW PLACE BALTIMORE MARYLAND 21217

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic obstructive pulmonary disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Yr +

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

1 Yr +

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mian Kp, MD

29c. License number

D31865

29d. Date signed (Month, Day, Year)

5/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mian-Oak Ridge, MD Rm 206 824 N. Gutter Street Baltimore, md 21207

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Spack

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16307

|   |   |                          |   |   |  |   |  |  |  |
|---|---|--------------------------|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Joseph Peter Bachman, III                       |                          |   |   | 2. Date of Death<br>Month Day Year<br>May 3, 1999  |   | 3. Time of Death<br>2:45 p.m.  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Atlantic General Hospital |                          |   |   | 4b. City, Town, or Location of Death<br>Berlin   |   | 4c. County of Death<br>Worcester   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>579-36-6990  |                          | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth (Month, Day, Year)<br>March 16, 1932  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                             |  |
|   | Usual Residence of Decedent   |                          |   |   |  |   |  |  |  |
| 10a. State<br>MD  |   | 10b. County<br>Worcester |   | 10c. City, Town or Location<br>Ocean City   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
| 10e. Street and Number<br>14400 Jarvis Avenue #115  |   |                          |   | 10f. Zip Code<br>21842  |  | 10g. Citizen of What Country?<br>USA                    |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales/Consulting   |  | 16b. Kind of Business/Industry<br>Computer              |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph Peter Bachman, Jr.  |   |                          |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Catharine Regina Goodwill  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Stacey Bachman-Baker  |   |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>713 E. South Street, Frederick, Maryland 21701   |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Baltimore Washington Cr.  |  | 20c. Location - City or Town, State<br>Laurel, Maryland |  | 20d. Date<br>5/10/99   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                          |   | 22. Name and Address of Facility<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road, Laurel, Maryland 20707  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                          |   |   |  |   |  |  | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                          |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                          |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                                |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 28d. Describe how injury occurred            |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                          |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D41306                           |  | 29d. Date signed (Month, Day, Year)<br>5/14/99                                       |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Pamela Zorn, M.D. Atlantic General Hospital, 9733 Health Way Dr., Berlin, MD  |   |                          |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |   |                          |   | 32. Registrar's Signature<br>  |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 16308

|   |  |   |  |  |   |  |  |
|---|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES GRADY BRYAN</b>                                   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>MAY 18, 1999</b> |  | 3. Time of Death<br><b>945PM</b>                             |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>                      |
| Funeral<br>Director   | 5. Social Security Number<br><b>412-42-0559</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth (Month, Day, Year)<br><b>8-13-28</b>  | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b> |
|   | Usual Residence of Decedent  |   |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>7428 St. Patricia Court</b>  |  |   |  | 10f. Zip Code<br><b>21222</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1946-47</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>G.E.D.</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Milkman</b>  |   | 16b. Kind of Business/Industry<br><b>Cloverland Dairy Co.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Clarence Bryan</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella Cannon</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. H. Beatrice Bryan/Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7428 St. Patricia Ct. Dundalk, Maryland 21222</b>  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wilson Cemetery</b>  |  | Date<br><b>5/24/1999</b>   |   | 20c. Location - City or Town, State<br><b>Elizabethton, TN</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |  |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.<br><br>a. <b>HEPATIC FAILURE</b><br>Due to (or as a consequence of):<br><br>b. <b>METASTATIC LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.         |  |   |  | Approximate Interval Between Onset and Death<br><b>1 day</b>   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how Injury occurred  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.  |  | 29c. License number<br><b>050228</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5-18-99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ERIK EWYAS, M.D. FSHC 9000 FRANKLIN SQ DRIVE, BALTIMORE, MD 21237</b>  |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16309

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Lois Lee Brooks</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 19, 1999</b>  |  | 3. Time of Death<br><b>4:15 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>8012 Penwood Ave.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Edgemere</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-30-2783</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 30, 1933</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Edgemere</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>8012 Penwood Ave.</b>   |  | 10f. Zip Code<br><b>21219</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 Years</b> College (1-4 or 5+)                 |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cafeteria Worker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Baltimore Co. Board of Education</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Frederick W. Lerch</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Erma Fowler</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Harold W. Brooks/Husband</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8012 Penwood Ave. Edgemere, Maryland 21219</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Park</b>   |  | 20c. Location - City or Town, State<br><b>Dorsey, Maryland</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. End-stage Chronic Obstructive Pulmonary Disease</b><br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death<br><b>10 years</b>  |  |   |  |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.   |  |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |
|   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year)  |  |  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
|   | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D40609</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/19/99</b>   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>North Point Medical Ctr, 1005 No Point Blvd - Suite 700, Baltimore, MD 21224</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |   |  |
|   | 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16310

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Loveland Bynion</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 19 1999</b>   |  | 3. Time of Death<br><b>4:15 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3913 Church Road</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Millers</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-40-2768</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 20 1940</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Millers</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>3913 Church Road</b>   |  | 10f. Zip Code<br><b>21102</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>n/a</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teller</b>  |  | 16b. Kind of Business/Industry<br><b>Banking</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harold V. Russell</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Eleanor Loveland</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cheryl L. Brennan/daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3913 Church Rd., Millers, MD 21102</b>   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>  |  | 20c. Location - City or Town, State<br><b>Timonium, MD</b>   |  | 20d. Date<br><b>5/22/99</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><br><b>Michael J. Flagle</b>   |  |   |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home</b><br><b>10 W. Padonia Rd., Timonium, MD 21093</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Emphysema</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><br><u>years</u> |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><br><b>George Lowe</b>  |  |   |  | 29c. License number<br><b>D20673</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/21/99</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George Lowe, M.D. 7672 Belair Rd., Baltimore, MD 21236</b>   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |   |  | 32. Registrar's Signature<br><br><b>B. Sparks</b>   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16311

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |  |   |  |
|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>LOUIS BARBAKOS</b>  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>19</b> Year <b>1999</b>  |   | 3. Time of Death<br><b>3:55 P.M.</b>   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |
| 5. Social Security Number<br><b>149-05 -7007</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 3 1915</b> | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>  |
| Usual Residence of Decedent  |  |  |   |  |
| 10a. State<br><b>Md.</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Essex</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>601 Seena Road</b>  |  | 10f. Zip Code<br><b>21221</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> Collega (1-4or 5+)   |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Welder</b>   |  | 16b. Kind of Business/Industry<br><b>RheemsWaterHeaters</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Basil Barbakos</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Aspacia Mahors</b>   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ella Barbakos / wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>601 Seena Road Baltimore Md. 21221</b>   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc.</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>  |
| 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>  |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hepatic Failure</b><br>Due to (or as a consequence of):<br><b>b. End Stage Liver Disease</b><br>Due to (or as a consequence of):<br><b>c. Liver Cirrhosis</b><br>Due to (or as a consequence of):<br><b>d. Hepatitis</b> |  |  |   | Approximate Interval Between Onset and Death<br><b>7 DAYS</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus, Hypothyroidism</b><br><b>Hypertension, Congestive Heart Failure</b><br><b>Lower Extremity Cellulitis</b>   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   | 28b. Time of Injury<br><b>M</b>                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |
| 29b. Signature and title of certifier<br><b>Dr. Marco Zamora MD</b>  |  | 29c. License number<br><b>D40819</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 19, 1999</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR MARCO ZAMORA 9000 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237</b>  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16312

|   |  |                          |   |   |  |                                 |  |  |   |  |  |
|---|--|--------------------------|---|---|--|---------------------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Bright</b>                                  |                          |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>19</b> Year <b>1999</b>  |                                 |  |  | 3. Time of Death<br><b>00:50 AM</b>                   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b> |                          |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                 |  |  | 4c. County of Death<br><b>NA</b>                      |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>246-38-0973</b>  |                          | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>07-02-19</b> |  | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |  |  |
|   | Usual Residence of Decedent  |                          |   |   |  |                                 |  |  |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |                                 |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><b>2236 Guilford Avenue</b>   |  |                          |   | 10f. Zip Code<br><b>21218</b>   |  |                                 |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4or 5+) <b>NA</b>  |  |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Janitorial</b>  |  |                                 |  | 16b. Kind of Business/Industry<br><b>Company</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Oscar Williams</b>  |  |                          |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Hattie Fuller</b>   |  |                                 |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Glover Williams</b>  |  |                          |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21213</b><br><b>3407 Kentucky Avenue Baltimore, Maryland</b>   |  |                                 |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kings Memorial Pk. Cem. 05-24-99 Randallstown, MD</b>  |  |                                 |  | 20c. Location - City or Town, State <b>MD</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                          |   | 22. Name and Address of Facility <b>Baltimore, Maryland 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b>   |  |                                 |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Carcinoid Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                          |   |   |  |                                 |  |  |   | Approximate Interval Between Onset and Death<br><b>4 Month</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HTN. Arteriosclerosis</b>  |  |                          |   |   |  |                                 |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|   |  |                          |   |   |  |                                 |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|   |  |                          |   |   |  |                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                          |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |                          |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|   |  |                          |   | 28d. Describe how injury occurred   |  |                                 |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                          |   |   |  |                                 |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Nan Ni, MD</b>  |  |                          |   | 29c. License number<br><b>AT2438946</b>   |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>May 19, 1999</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nan Ni, MD</b><br><b>Union Memorial Hospital 201 E. University Parkway Baltimore, MD 21218</b>   |  |                          |   |   |  |                                 |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |                          |   | 32. Registrar's Signature<br>   |  |                                 |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Helen Virgie Bright  
Division of Vital Records, P.O. Box 68760,

6

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#20b &amp; 20c PER F.H. G771 5/20/99 J.A.

## Certificate of Death

Reg. No.

99 16313

|  |   |   |  |   |  |  |  |  |
|--|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Loretta C. Bien</b>                              |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MAY 19 1999</b>   |  | 3. Time of Death<br><b>1:30 P.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b> |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-05-0235</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>93</b> Yrs.  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 24, 1905</b>  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                          |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |  |
| 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Pasadena</b>  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1670 Kwickenham Rd.</b>   |   |   |  | 10f. Zip Code<br><b>21122</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Telephone Operator</b>  |  |  | 16b. Kind of Business/Industry<br><b>C &amp; P</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John E. Schneider</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna C. Grimes</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>J. LaRue Churchman/Sister</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2707 Finch Rd., Glen Burnie, Md. 21061</b>  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTO. METRO CREMATORY</b>   |  | 20c. Location - City or Town, State<br><b>5-21-99 CATTONSVILLE, Md.</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Dean D. Imberger</b>   |   |   |  | 22. Name and Address of Facility<br><b>AMERICK FUNERAL HOME<br/>1325 SULLY SPRING RD PASADENA 21127</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  |   |   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |
|  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  | 29b. Signature and title of certifier<br><b>MD</b>  |  | 29c. License number<br><b>D43977</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>May 19 1999</b>                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CYNTHIA DEETUN JR. 301 HOSPITAL DRIVE, GLEN BURNIE, MD. 21061</b>   |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |   |  | 32. Registrar's Signature<br><b>Beverly B. Sparks</b>   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BEATRICE K. BASOA

2. Date of Death

Month Day Year  
APRIL 24, 1999

3. Time of Death

5:55 A.M.

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

UNKNOWN

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 15, 1949

9. Birthplace (State or Foreign Country)

GHANA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11620 STEWART LANE #203

10f. Zip Code

20904

10g. Citizen of What Country?

GHANA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOSEPH AMISSAH

18. Mother's Name (First, Middle, Maiden Surname)

ABENE ASANTEWAA

19a. Informant's Name/Relationship (Type, Print)

MARTIN K. BASOA/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11620 STEWART LANE #203 SILVER SPRING, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ACCRA, GHANA

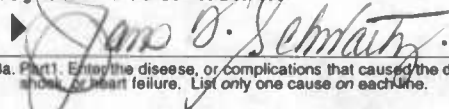
Date

25MAY99

20c. Location - City or Town, State

ACCRA, GHANA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.  
11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARDIOPULMONARY FAILURE

Due to (or as a consequence of):

b. END STAGE RENAL DISEASE

Due to (or as a consequence of):

c. MULTIPLE MYELOMA

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

MINUTES

CHRONIC

CHRONIC

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

44777

29d. Date signed (Month, Day, Year)

APRIL 28, 1999

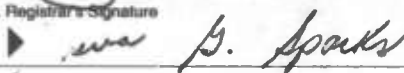
30. Name and address of person who completed cause of death (Form 23a) (Type, Print)

MARUTHI S. MANNEY, M.D. 3401 RESEARCH BLVD. ROCKVILLE, MD 20895

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

15315

Reg. No.

|   |   |                                 |  |   |  |   |   |  |   |
|---|---|---------------------------------|--|---|--|---|---|--|---|
| <b>Physician<br/>/Medical<br/>Examiner</b>  | 1. Decedent's Name (First, Middle, Last)<br><b>Nancy L. Buschman</b>                      |                                 |  |   |  | 2. Date of Death<br>Month: <b>May</b> Day: <b>9</b> Year: <b>1999</b>   |   | 3. Time of Death<br><b>8:25 pm</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center</b> |                                 |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |   |
| <b>Funeral<br/>Director</b>   | 5. Social Security Number<br><b>215-28-1159</b>   |                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  | If Under 1 Year<br>Months: Days:   | If Under 24 Hrs.<br>Hours: Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 29, 1927</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>NEW York</b> |
|   | Usual Residence of Decedent   |                                 |  |   |  |   |   |  |   |
| 10e. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b> |  | 10c. City, Town or Location<br><b>Lutherville</b> |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>522 Riderwood</b>  |   |                                 |  |   | 10f. Zip Code<br><b>21093</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>12</b> College (1-4 or 5+): <b>2</b>   |   |                                 |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesperson</b>  |   |   | 16b. Kind of Business/Industry<br><b>retail</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank William Watkins</b>   |   |                                 |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice Blake</b>  |   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lynn Rauh/daughter</b>   |   |                                 |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8507 Wellington Valley Way, Lutherville, MD 21093</b>                                    |   |   |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)   |   | Data   |   | 20c. Location - City or Town, State   |  |   |
| 21. Signature of Funeral Service Licensee<br> <b>Ronald S. Wade, Director</b>   |   |                                 |  |   | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>  |   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Lung Cancer</b></p> <p>Due to (or as a consequence of):</p> <p>b. _____</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 35%; border-left: 1px dashed black; padding-left: 10px;"> <p>Approximate Interval Between Onset and Death</p> <p><b>1 1/2 years</b></p> </div> </div> |   |                                 |  |   |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                 |  |   |  |   |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |                                 |  |   |  |   |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                 |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |  |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |                                 | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                                 |  |   |  |   |   |  |   |
| 29b. Signature and title of certifier<br> <b>W.A. Riley, M.D.</b>  |   |                                 |  |   | 29c. License number<br><b>D25205</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>May 10, 1999</b>                                  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W.A. Riley, M.D. 6701 N. Charles St. Balto. md 21204</b>   |   |                                 |  |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |   |                                 | 32. Registrar's Signature<br>  |   |  |   |   |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Nancy LEE BUSCHMAN MAY 9, 1999 8:30 PM  
 Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





99-2893-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

LYNELLE

ITEMS: #23 PART I PER MEO State of Maryland / Department of Health and Mental Hygiene 99 16316

CHATMAN

AMENDED #10e PER FH G 771 5/21/99 AH

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Lynelle Chatman</u>  |  |   |  | 2. Date of Death<br>Month <u>MAY</u> Day <u>18</u> Year <u>1999</u>  |  | 3. Time of Death<br><u>4:57P.M.</u>  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><u>332 S. MONROE STREET</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>   |  | 4c. County of Death  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>214-64-0446</u>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>44</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>12 26 55</u>   |  |
|   | Usual Residence of Decedent   |  | 9. Birthplace (State or Foreign Country)<br><u>North Carolina</u>   |  | 10. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><u>Md</u>   |  | 10b. County<br><u>N/A</u>   |  | 10c. City, Town or Location<br><u>Baltimore</u>  |  | 10d. Inside City Limits  |  |
|   | 10e. Street and Number<br><u>332 S MONROE STREET</u>  |  | 10f. Zip Code<br><u>21201</u>   |  | 10g. Citizen of What Country?<br><u>USA</u>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12th</u> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>UKN.</u>  |  | 16b. Kind of Business/Industry<br><u>UKN.</u>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><u>UKN.</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>MARY MILLS</u>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Nicole Chatman - Daughter</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2122 Mura Street Baltimore, Maryland 21213</u>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metro Crematory</u>  |  | Date<br><u>5-20-99</u>   |  | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>  |  |
|   | 21. Signature of Funeral Service Licensee<br><u>Jeff Miller</u>   |  | 22. Name and Address of Facility<br><u>Jeff Miller P.C. Funeral Home &amp; Services</u><br><u>1639 N. Broadway Baltimore, Md. 21213</u>   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>ACQUIRED IMMUNODEFICIENCY SYNDROME</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospitol: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29e. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| State Registrar                               | 29b. Signature and title of certifier<br><u>Heather Mitchell</u>  |  | 29c. License number<br><u>O.C.M.E.</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>MAY 19, 1999</u>   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Ms Lydara Koon</u> <u>111 Penn Street, Baltimore, Maryland 21201</u>   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><u>MAY 21 1999</u>   |  | 32. Registrar's Signature<br><u>B. Sparks</u>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

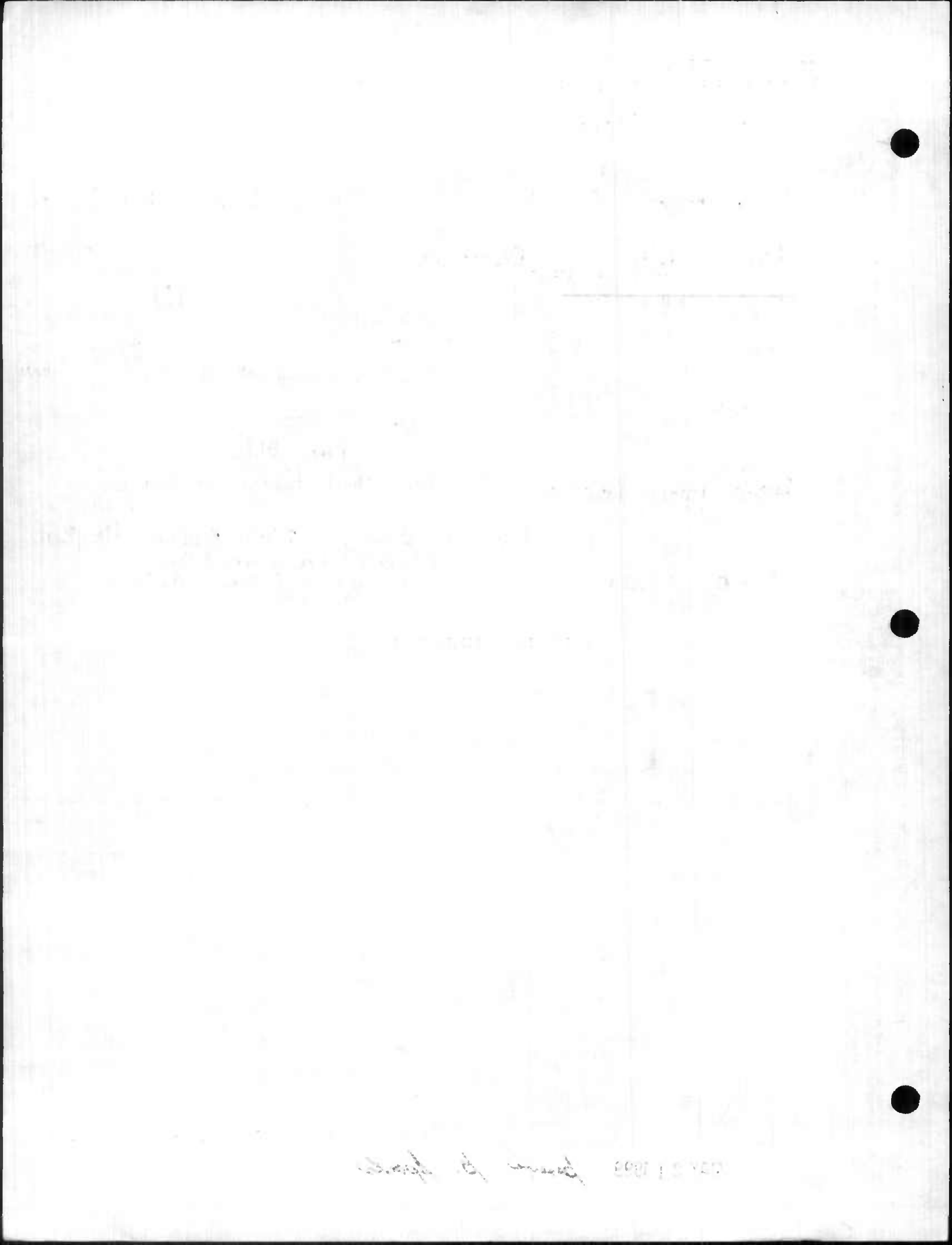
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



jhm  
RUDOLPH  
CAMPBELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

89 16317

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>RUDOLPH M. CAMPBELL  |  |   |  | 2. Date of Death<br>Month Day Year<br>MAY 18, 1999   |  | 3. Time of Death<br>09:34 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>2138 PRESSTMAN STREET  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>219 28 4155   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>66 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>09-26-32                                      |  |
|   | 9. Birthplace (State or Foreign Country)<br>MD   |  | 10a. State<br>MD  |  | 10b. County<br>N/A   |  | 10c. City, Town or Location<br>BALTIMORE CITY  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>2138 PRESSTMAN ST.  |  | 10f. Zip Code<br>21217   |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10<br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>ENGINEER   |  | 16b. Kind of Business/Industry<br>BALTO. CITY SCHOOLS  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>WILLIAM RITTENHOUSE   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>JEANETTE DORSEY   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>SHIRLEY CAMPBELL/WIFE  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2138 PRESSTMAN ST. BALTO., MD. 21217  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>New Cathedral Cem.  |  | 20c. Location - City or Town, State<br>Baltimore, Md.  |  | 20d. Date<br>5/27/99   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>James A. Morton</i>  |  |   |  | 22. Name and Address of Facility<br>JAMES A. MORTON & SONS FUNERAL HOMES, INC.<br>1701 LAURENS ST. BALTO., MD. 21217   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Hypertensive Arteriosclerosis</i><br>Due to (or as a consequence of):<br>b. <i>Coronary Artery Disease</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death   |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Alcoholism</i><br><i>Severe Disorder</i>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>David L. Lohman</i>  |  |   |  | 29c. License number<br>OCME  |  | 29d. Date signed (Month, Day, Year)<br>MAY 19, 1999                                  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>J. Aaron Locke, MD</i> 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>MAY 21 1999   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |  |  |

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16318

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY CAWTHORNE

2. Date of Death

Month  
5Day  
12Year  
1999

3. Time of Death

7:00 AM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

233-56-9988

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Nov. 4, 1935

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6420 Darwin Road

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Robert Hicks

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Virginia Walker

19a. Informant's Name/Relationship (Type, Print)

Michael Hicks/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8125 High Meadow Court, Ellicott City, MD 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Memorial Garden 5/17/99 Bluewell, West Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. BREAST CANCER  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HEPATO-RENAL FAILURE  
Due to (or as a consequence of):c. CARDIORESPIRATORY ARREST  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death  
~ 1 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☒ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45014

29d. Date signed (Month, Day, Year)

MAY 12/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8379 CHERRY LANE LAUREL MD 20707

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general  
description of the project and its objectives.

2. The second part of the report is a detailed  
description of the methodology used in the study.  
3. The third part of the report is a description  
of the results of the study.

4. The fourth part of the report is a discussion  
of the results and their implications.

5. The fifth part of the report is a conclusion  
and a list of references.

6. The sixth part of the report is a list of  
appendices.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16319

|   |   |   |  |  |   |  |  |                                      |  |
|---|---|---|--|--|---|--|--|--------------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Marie Cesta                           |   |  |  | 2. Date of Death<br>Month Day Year<br>5 20 99   |  | 3. Time of Death<br>11:30 PM                         |                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>6906 Markel Ave |   |  |  | 4b. City, Town, or Location of Death<br>Dundalk |  | 4c. County of Death<br>Baltimore                     |                                      |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-26-8302  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>71 Yrs.       |  | 8. Date of Birth (Month, Day, Year)<br>April 25 1928 |                                      |  |
|   | 9. Birthplace (State or Foreign Country)<br>MD                                    |   | 10a. State<br>MD   |  | 10b. County<br>Baltimore                        |  | 10c. City, Town or Location<br>Dundalk               |                                      |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>6906 Markel Ave  |   | 10f. Zip Code<br>21222   |  | 10g. Citizen of What Country?<br>USA |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |   |  |  |                                      |  |
| 17. Father's Name (First, Middle, Last)<br>John Shkor   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna Strygelski   |   |  |  |                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Louis R. Cesta /husband   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6906 Markel Ave Baltimore, MD 21222   |   |  |  |                                      |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory   |  | Date<br>May 21 1999  |   | 20c. Location - City or Town, State<br>Catonsville, MD   |  |                                      |  |
| 21. Signature of Funeral Service Licensee<br>Anthony C. Connelly  |   |   |  | 22. Name and Address of Facility<br>Connelly Funeral Home of Dundalk<br>7110 Sollers Point Rd 21222  |   |  |  |                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic Mesothelioma<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  | Approximate Interval Between Onset and Death   |   |  |  |                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                      |  |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                      |  |
|   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |                                      |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred    |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |                                      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |   |  |  |                                      |  |
| 29b. Signature and title of certifier<br>Larry Waterbury, L.D.  |   |   |  | 29c. License number<br>DO 9559   |   | 29d. Date signed (Month, Day, Year)<br>5/21/99   |  |                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>LARRY WATERBURY, L.D. JABHC, 4940 Eastern Ave, Balt., Md. 21224   |   |   |  |  |   |  |  |                                      |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |   | 32. Registrar's Signature<br>B. Sparks  |  |  |   |  |  |                                      |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

89 16320

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine Emma Cavey

2. Date of Death  
Month Day Year  
May 18, 19993. Time of Death  
8:32 A.M.

4a. Facility Name (If not institution, give street and number)

University of Maryland, Shock Trauma

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-28-4132

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 18, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3503 Keck Avenue

10f. Zip Code

21133

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Stump Harvey Insurance

17. Father's Name (First, Middle, Last)

William Hoffman

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Schildwachter

19a. Informant's Name/Relationship (Type, Print)

Sharon Nardone (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Howard Road, Stevensville, MD 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

Date

5/22/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Sharon L. Lemmer

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Head and Hip Injuries

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

Approval

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☒ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

05-17-1999

28b. Time of Injury

11:30P

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

A home.

28d. Describe how injury occurred

Subject fell

down a flight of stairs.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1007 Elm Ridge Ave.

Carroll, Maryland 21229

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

*[Faint handwritten signature]*

2001 7 5 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16321

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary S. Conner

2. Date of Death

May

Day

17

Year

1999

3. Time of Death

21<sup>00</sup> Pm.

4a. Facility Name (If not institution, give street and number)

St Agnes health care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-03-6025

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

11/30/1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

112 Sanford Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward I. Streckfus

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Sontag

19a. Informant's Name/Relationship (Type, Print)

Robert Conner/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112 Sanford Avenue, Catonsville, Md. 21228

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mountain View Cemetery

Date

5/20/99

20c. Location - City or Town, State

Marriottsville, Md

21. Signature of Funeral Service Licensee

Mozk Marshall

22. Name and Address of Facility

Sterling-Ashton-Schwab Funeral Home, Inc  
736 Edmondson Avenue, Balto, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Congestive heart failure

Due to (or as a consequence of):

d. Mitral stenosis

Approximate Interval Between Onset and Death

20 years

10 years

15 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Hepatoma

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mallah M.D.

29c. License number

P12595

29d. Date signed (Month, Day, Year)

May 17 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mustapha Mallah M.D.

St Agnes Hospital - 900 Catin Avenue

Baltimore, MD. 21229

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Signature of Registrar

Sparks

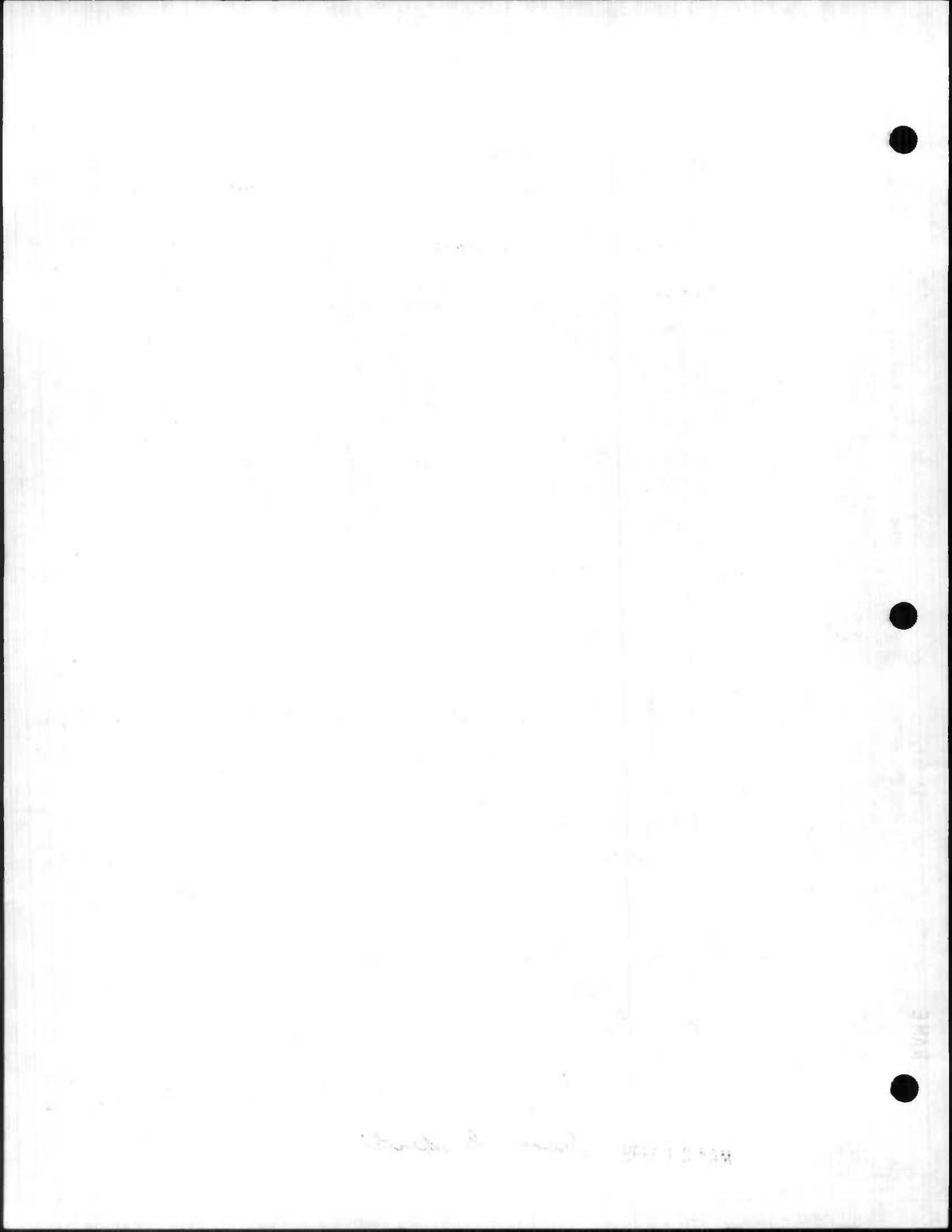
State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NAME Mary S Conner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16322

Costello, Agnes T.  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                              |  |   |  |  |  |  |  |  |  |                                   |  |
|------------------------------|--|---|--|--|--|--|--|--|--|-----------------------------------|--|
| Physician / Medical Examiner |  | 1. Decedent's Name (First, Middle, Last)<br><b>AGNES TERESA COSTELLO</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>MAY 19 1999</b>   |  | 3. Time of Death<br><b>0930 AM</b>   |  |                                   |  |
| Funeral Director             |  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |  |  |                                   |  |
|                              |  | 5. Social Security Number<br><b>218-07-3925</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>7/9/12</b>                                 |  |                                   |  |
|                              |  | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>                                 |  |                                   |  |
|                              |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3127 GUILFORD AVENUE</b>  |  | 10f. Zip Code<br><b>21218</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |                                   |  |
|                              |  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |                                   |  |
|                              |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b><br>College (1-4 or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |  |  |                                   |  |
|                              |  | 17. Father's Name (First, Middle, Last)<br><b>HUGH COSTELLO</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA WEBER</b>   |  |  |  |                                   |  |
|                              |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>DORIS SINGER NIECE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3127 GUILFORD AVENUE BALTIMORE, MD 21218</b>   |  |  |  |  |  |                                   |  |
|                              |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MOST HOLY REDEEMER CEM.</b>   |  | Data<br><b>5/24/99</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>                          |  |                                   |  |
|                              |  | 21. Signature of Funeral Service Licensee<br><i>Heather N. Hays</i>   |  | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>   |  |  |  |  |  |                                   |  |
|                              |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><b>SEPSIS</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 DAYS</b><br><b>10 DAYS</b>   |                                   |  |
|                              |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                   |  |
|                              |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                   |  |
|                              |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |                                   |  |
|                              |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
|                              |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |                                   |  |
|                              |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |                                   |  |
|                              |  | 29b. Signature and title of certifier<br><i>Natividad D. de Leon, M.D.</i>  |  |  |  | 29c. License number<br><b>D 19508</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 19, 1999</b>                           |  |                                   |  |
|                              |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NATIVIDAD DE LEON M.D. 7601 OSLER DRIVE TOWSON MARYLAND 21204</b>  |  |  |  |  |  |  |  |                                   |  |
|                              |  | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  | 32. Registrar's Signature<br><i>Barbara B. Sparks</i>  |  |  |  |  |  |                                   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

ITEMS: #24A PER MD G771 5-21-99 WR.

99 16323

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |                                |   |  |
|--|--|---|--|--|--------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Norman G. Davis</b>   |  |   |  | 2. Date of Death<br>Month <b>April</b> Day <b>29</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>7:25 pm</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Continuum Care Sykesville</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Sykesville</b>  |                                | 4c. County of Death<br><b>Carroll</b>   |  |
| 5. Social Security Number<br><b>214-26-6839</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 13, 1929</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |                                |   |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Sykesville</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 10e. Street and Number<br><b>7302 Second Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21784</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1952</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>0</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Barber</b>   |                                | 16b. Kind of Business/Industry<br><b>Own business</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Feodor Robert Davis</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Marie Grammer</b>  |                                |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>unknown</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>unknown</b>  |                                |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date   |                                | 20c. Location - City or Town, State   |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |   |  | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>  |                                |   |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Acute Myelomonocytic</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Leukemia - Lymphocytic</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Poor P.O. intake</b><br/>Due to (or as a consequence of):</p> <p>d. <b>Serotonin Hemolysis</b></p> </div> </div> |  |   |  |  |                                |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chest pains</b>   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |                                |   |  |
| 29b. Signature and title of certifier<br><b>Dr. Alexander L. ...</b>   |  |   |  | 29c. License number<br><b>D30119</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>5/6/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>SHAHIDA SIDDIQI 6212 SYKESVILLE ROAD 21784</b>  |  |   |  |  |                                |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 22 1999</b>  |  | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>  |  |  |                                |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

10/10/1910

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

SHAWN DORSEY ITEMS: #23 PART 1, 27, 28A-F PER MEO

G772 6-1-99 WR.

99 16324

|  |   |   |  |   |  |  |                                    |
|--|---|---|--|---|--|--|------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SHAWN ALBERT DORSEY</b>                  |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MAY 18 1999</b> |  | 3. Time of Death<br><b>12:40 A</b> |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b> |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-86-1161</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>29</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth (Month, Day, Year)<br><b>FEB 27 1970</b>                                      |                                    |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                             |   |  |   |  |  |                                    |
| Usual Residence of Decedent  |   |   |  |   |  |  |                                    |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                    |
| 10e. Street and Number<br><b>4201 PENHURST AVE</b>   |   |   |  | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |                                    |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |                                    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th grade</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Worker</b>   |  | 16b. Kind of Business/Industry<br><b>Private Business</b>                                      |                                    |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL GARLAND</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NANCY DORSEY</b>  |  |  |                                    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DOROTHY GARLAND</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4201 PENHURST AVE BALTIMORE, MD 21215</b>   |  |  |                                    |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | Date<br><b>5/22/99</b>  |  | 20c. Location - City or Town, State<br><b>WOODPLAWN, Maryland</b>                              |                                    |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |   |   |  | 22. Name and Address of Facility<br><b>CHATHAM HOSPITAL<br/>5340 REISTERSTOWN RD<br/>BALTIMORE, MD 21215</b>  |  |  |                                    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |   |  |  |                                    |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                    |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>Found: 5-18-99</b>   |  | 28b. Time of Injury<br><b>Found: 12:08</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                    |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE</b>   |   |   |  | 28d. Describe how injury occurred<br><b>UNKNOWN</b>   |  |  |                                    |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4201 PENHURST AVE, BALTIMORE MD.</b>  |   |   |  |   |  |  |                                    |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |   |  |  |                                    |
| 29b. Signature and title of certifier<br><b>Theodore M. King</b>   |   |   |  | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 18, 1999</b>                                     |                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |   |  |  |                                    |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |                                    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1917

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amended Item 22, PER FH, G771.5/21/99/dhb

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARL J. DAVIS III

2. Date of Death

MAY

8

1999

3. Time of Death

2204

4a. Facility Name (If not institution, give street and number)

THE Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore, City

4c. County of Death

MD

5. Social Security Number

NONE

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

0

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MAY 8, 1999

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1207 E. FEDERAL STREET

10f. Zip Code

21202

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFR. AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

CARL J. DAVIS JR

18. Mother's Name (First, Middle, Maiden Surname)

LATRICE RIVERS

19a. Informant's Name/Relationship (Type, Print)

LATRICE RIVERS (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1207 E. FEDERAL STREET BALTO. MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WESTERN STAR CEMETERY 5/17/1999

Date

20c. Location - City or Town, State

CATONSVILLE MD

21. Signature of Funeral Service Licensed

EUGENE N WALKER

22. Name and Address of Facility

EAP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PLACE BALTO. MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

FETAL PNEUMONIA AND SEPSIS

Approximate Interval Between Onset and Death

IN UTERO

Due to (or as a consequence of):

MATERNAL CHORIOAMNIONITIS

IN UTERO

Due to (or as a consequence of):

IN UTERO MECONIUM ASPIRATION

IN UTERO

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D51295

29d. Date signed (Month, Day, Year)

MAY 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAVIER E. REPETTO, MD

THE JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST, BALTIMORE, MD

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN STRECKER DUVALL

2. Date of Death

Month Day Year MAY 20 1999

3. Time of Death

1:30 AM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

215-03-9081

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Oct. 05 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel Co.

10c. City, Town or Location

Gibson Island

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

421 Aberfoyle Road

10f. Zip Code

21056

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 8

College (1-4 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Telephone Company

17. Father's Name (First, Middle, Last)

Charles Strecker

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Kohlhoff

19a. Informant's Name/Relationship (Type, Print)

Betty Blake (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

808 Wilda Drive, Westminster, Md. 21157-8352

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park 5/24/99 Glen Burnie, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*David A. Hayle*

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.  
3204 Mountain Road, Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY

MRSA in SPOTUM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

DS1245

29d. Date signed (Month, Day, Year)

MAY 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAJID SHARIF NORTH ARUNDEL HOSPITAL - MD.

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

*[Signature]* B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |                                     |  |
|---|--|---|---|--|--|--|-------------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>James Lee Dennis, Sr.                |   |   |  | 2. Date of Death<br>Month Day Year<br>MAY 18, 1999   |  | 3. Time of Death<br>07:05 AM        |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>239 Iron Shire |   |   |  | 4b. City, Town, or Location of Death<br>Laurel       |  | 4c. County of Death<br>ANNE ARUNDEL |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-94-7461   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>34 Yrs. | 8. Date of Birth (Month, Day, Year)<br>Sept. 6, 1964   | 9. Birthplace (State or Foreign Country)<br>Maryland |  |                                     |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |                                     |  |
| 10a. State<br>MD  |  | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Laurel  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                     |  |
| 10e. Street and Number<br>239 Ironshire South   |  |   |   | 10f. Zip Code<br>20724   |  | 10g. Citizen of What Country?<br>USA   |                                     |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Hotel Desk Agent  |  | 16b. Kind of Business/Industry<br>Hotel  |                                     |  |
| 17. Father's Name (First, Middle, Last)<br>Philip A. Dennis   |  |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br>Linda Walker  |  |  |                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Angela Dennis/Wife  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>239 Ironshire South, Laurel, Maryland 20724   |  |  |                                     |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Prk  |   | 20c. Location - City or Town, State<br>Elkridge, Maryland  |  | 20d. Date<br>5/22/99   |                                     |  |
| 21. Signature of Funeral Director<br>   |  |   |   | 22. Name and Address of Facility<br>Fleck Funeral Home, Inc.<br>7601 Sandy Spring Road, Laurel, Maryland 20707   |  |  |                                     |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. HYPERTENSIVE CARDIOVASCULAR DISEASE<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |  |                                     |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |  |  |  |                                     |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  |  |                                     |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |  |  |                                     |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |                                     |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |                                     |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28d. Describe how injury occurred  |  |  |                                     |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |  |                                     |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |  |                                     |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br>OCME  |  | 29d. Date signed (Month, Day, Year)<br>MAY 18, 1999  |                                     |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestana, 11 Penn Street, Baltimore, Maryland 21201   |  |   |   |  |  |  |                                     |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |  |   |   | 32. Registrar's Signature<br>  |  |  |                                     |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16328

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nellie N. Davis

2. Date of Death

MAY 14, 1999

3. Time of Death

4:20 AM

4a. Facility Name (If not institution, give street and number)

5105 4th Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

276-22-4435

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 18, 1899

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Anne Arundel10c. City, Town or Location  
Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5105 4th Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Russell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Agnes Bartholomew

19a. Informant's Name/Relationship (Type, Print)

Carol Windsor / Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5105 4th Street Baltimore, Maryland 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

Date

5/17/99

20c. Location - City or Town, State

Towson Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George J. Gonce Funeral Home  
P.A. 4001 Ritchie Highway Baltimore, Md 2122523a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Decedent

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

26a. Date of Injury

(Month, Day, Year)

26b. Time of Injury

M

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)26f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19667

29d. Date signed (Month, Day, Year)

5-14-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Schwartz M.D. 5517 Ritchie Highway, Baltimore, Maryland 21225

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

NELLIE DAVIS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16329

Deublein, William

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |   |  |  |   |  |                          |  |  |  |  |  |
|--|---|--|--|---|--|--------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>William Paul Deublein                                 |  |  |   | 2. Date of Death<br>Month Day Year<br>MAY 15, 1999 |                          |  |  | 3. Time of Death<br>3:45 P.M.                          |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL CENTER |  |  |   | 4b. City, Town, or Location of Death<br>ROSEDALE   |                          |  |  | 4c. County of Death<br>BALTIMORE                       |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>145-24-3513  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>68               |                          | 8. Date of Birth (Month, Day, Year)<br>August 31, 1930 |  | 9. Birthplace (State or Foreign Country)<br>New Jersey |  |  |
|  | Usual Residence of Decedent   |  |  |   |  |                          |  |  |  |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Harford   |  | 10c. City, Town or Location<br>Bel Air  |  |                          |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>445-2 Mooresmill Road  |   |  |  | 10f. Zip Code<br>21014  |  |                          |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 10/48 10/52 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 yrs.<br>College (1-4 or 5+) n/a  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Machine Operator   |  |                          |  | 16b. Kind of Business/Industry<br>Lever Brothers   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Alphonse Deublein   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna Tonjann   |  |                          |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Alicia A. Lynch (Daughter)  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2413 Derby Drive Fallston, MD. 21047   |  |                          |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bakers Cemetery   |  | Date<br>5/20/99          |  | 20c. Location - City or Town, State<br>Aberdeen, Maryland 21001  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>E. J. Lassahn   |   |  |  | 22. Name and Address of Facility<br>E. J. Lassahn Funeral Home<br>11750 Belair Road Kingsville, MD. 21087   |  |                          |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Squamous Cell Carinoma of Lung<br>Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |  |  |   |  |                          |  |  |  | Approximate Interval Between Onset and Death<br>1 Hour |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  |                          |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |   |  |  |   |  |                          |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |   |  |  |   |  |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                          |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                      |  |
|  |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |  |   |  |                          |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Deborah Gallo   |   |  |  | 29c. License number<br>RD # 187187  |  |                          |  | 29d. Date signed (Month, Day, Year)<br>5/15/99   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. DEBORAH GALLO 9000 FRANKLIN SQUARE DR BALTO, MD. 21237   |   |  |  |   |  |                          |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999   |   |  |  | 32. Registrar's Signature<br>B. Apol...   |  |                          |  |  |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16330

|   |  |  |  |   |  |   |   |  |   |  |
|---|--|--|--|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>David Glenn Ellers</b>  |  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 15, 1999</b>   |   | 3. Time of Death<br><b>9:30 P.M.</b>   |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital</b>  |  |  |   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |   | 4c. County of Death<br><b>Howard</b>   |   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-24-9070</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>July 24, 1928</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent  |  |  |   |  |   |   |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>   |   | 10c. City, Town or Location<br><b>Marriottsville</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>2165 Mountain View Road</b>   |  |  |   | 10f. Zip Code<br><b>21104</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1951-59</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) <b>2 Years</b>  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanical Engineer</b> |  |   | 16b. Kind of Business/Industry<br><b>Westinghouse</b>                                       |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Benjamin Frank Ellers</b>  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Elizabeth Glenn</b>   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charles M. Jenkins-Personal Rep</b>   |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7670 Smiths Private Road Sykesville, MD 21784</b>   |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crestlawn Mem. Gardens</b>  |   |  | Date<br><b>5/21/99</b>  |   | 20c. Location - City or Town, State<br><b>Marriottsville, MD</b>                               |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. COMPLETE HEART BLOCK, VENTRICULAR ASYSTOLE</b> MINUTES<br>Due to (or as a consequence of):<br><b>b. ACUTE MYOCARDIAL INFARCTION</b> 6 HOURS<br>Due to (or as a consequence of):<br><b>c. CORONARY ARTERY DISEASE WITH ISCHEMIC CARDIOMYOPATHY</b> YEARS<br>Due to (or as a consequence of):<br><b>d.</b> |  |  |   |  |   |   |  |   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ETHANOL ABUSE</b><br><b>CIGARETTE ABUSE</b>  |  |  |   |  |   |   |  |   |  |
| Physician<br>/Medical<br>Examiner             | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>NONE</b>   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |  | 29c. License number<br><b>D16810</b>  |   |  |   |  |
|   | 29b. Signature and title of certifier<br>   |  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 16, 1999</b>  |   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM D PARNES M.D 11085 LITTLE PATUENT PKWY, COLUMBIA MD 21044</b>   |  |  |   |  |   |   |  |   |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |  |   |  | 32. Registrar's Signature<br>   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16331

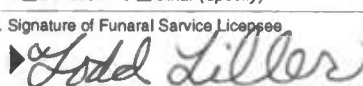
Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>VIRGIL E. EARLYWINE</b>  |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>15</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>10:00 A.M.</b>                                   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>8310 Fremont Street</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>New Carrollton</b>  |  | 4c. County of Death<br><b>Prince George's</b>                           |  |
| 5. Social Security Number<br><b>305 42 3579</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 14, 1912</b>             |  |
| 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>New Carrollton</b>                    |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>8310 Fremont Street</b>   |  | 10f. Zip Code<br><b>20784</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>32-59</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> Collage (1-4or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warrant Officer</b>                            |  | 16b. Kind of Business/Industry<br><b>United States Navy</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Earlywine</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maude Albright</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mildred Earlywine Wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8310 Fremont Street New Carrollton MD 20784</b>  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Arlington Virginia</b>   |  | 20d. Date<br><b>May 26, 1999</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Maryland 20715</b>                                     |  |  |  |   |  |

Physician  
/Medical  
Examiner

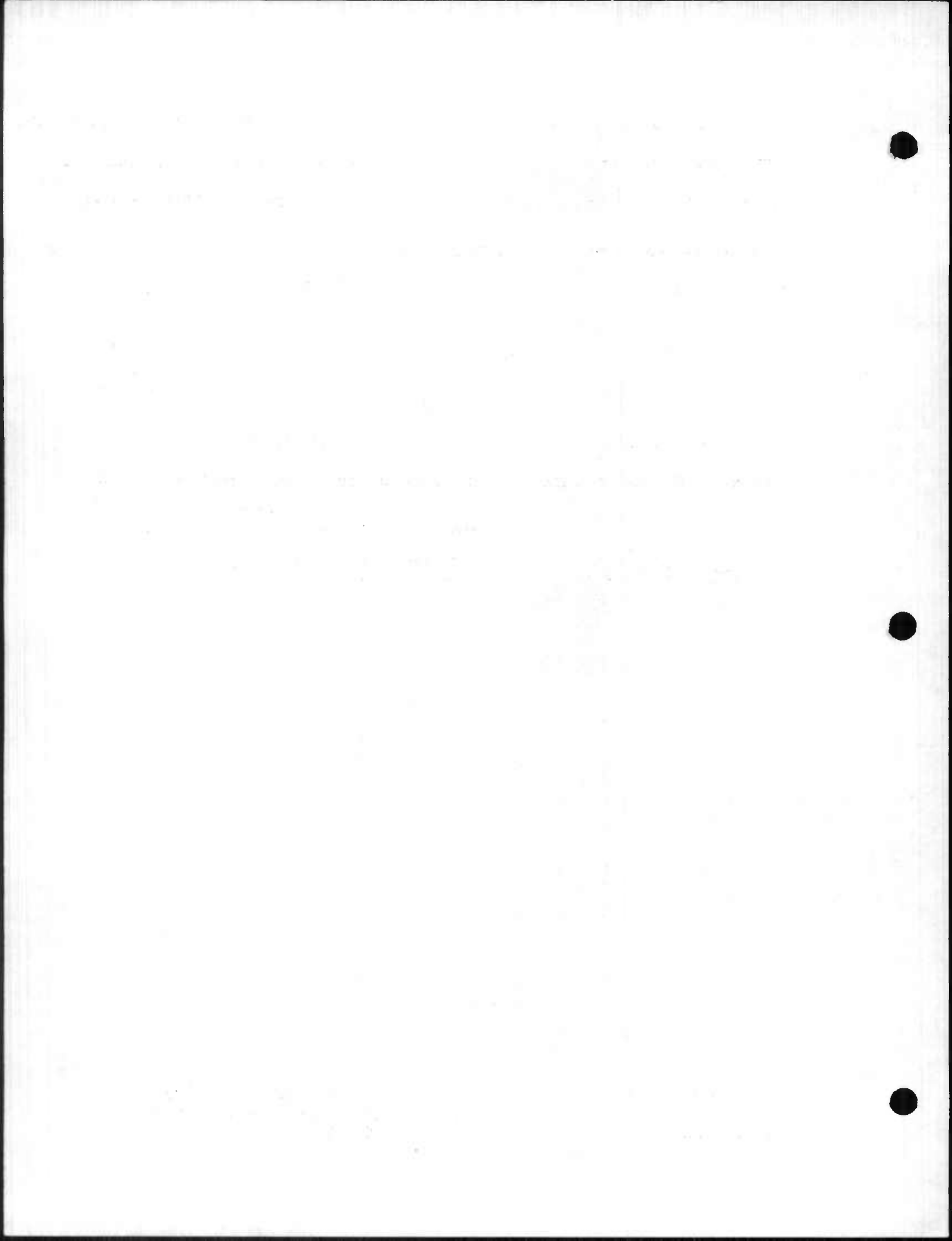
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CHOLANGIOCARCINOMA</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death                    |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                                 |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred                               |  |  |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>0101-056626 (VA)</b>                  |  | 29d. Date signed (Month, Day, Year)<br><b>5/17/1999</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>C.A. TANNA, LT, MC, USNR</b>  |  |   |  | <b>NATIONAL NAVAL MEDICAL CENTER<br/>BETHESDA MD 20889-5600</b> |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br>   |  |   |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16332

|  |  |   |   |  |  |  |  |  |   |   |   |  |  |  |
|--|--|---|---|--|--|--|--|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARY JANE ELLWOOD</b>   |   |   |  | 2. Date of Death<br>Month <b>5</b> Day <b>17</b> Year <b>99</b>  |  | 3. Time of Death<br><b>8:05 am</b>   |  |   |   |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>12455 Wolbert Way</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Bradshaw</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |   |   |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-36-4166</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs. | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 23, 1938</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Baltimore City, MD.</b>                         |  |   |   |   |  |  |  |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |  |   |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Bradshaw</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |   |  |  |  |
|  | 10e. Street and Number<br><b>12455 Wolbert Way</b>   |   |   |  | 10f. Zip Code<br><b>21021</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |   |   |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |   |   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b>n/a</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Admission Registrar</b>           |  | 16b. Kind of Business/Industry<br><b>Franklin Square Hospital</b>  |  |  |  |   |   |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Clifford Alonzo Snyder</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Mary Fortuna</b>  |  |  |  |   |   |   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James V. Ellwood (Husband)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12455 Wolbert Way Bradshaw, Maryland 21021</b>   |  |  |  |   |   |   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BelAir Memorial Gardens</b>  |  | 20c. Location - City or Town, State<br><b>5/20/99 BelAir, Maryland 21014</b>   |  |  |  |   |   |   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>E. F. Lassahn</b>  |   |   |  | 22. Name and Address of Facility<br><b>E. F. Lassahn Funeral Home<br/>11750 Belair Road Kingsville, Maryland 21087</b>   |  |  |  |   |   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |  |   |   |   |  |  |  |
|  | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>LUNG CANCER</b><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>45 yrs.<br/>20 yrs</b></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>COPD</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>SMOKER</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>LUNG CANCER</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>45 yrs.<br/>20 yrs</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>COPD</b><br>Due to (or as a consequence of): | c. <b>SMOKER</b><br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)  | a. <b>LUNG CANCER</b><br>Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><b>45 yrs.<br/>20 yrs</b>   |   |  |  |  |  |  |   |   |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. <b>COPD</b><br>Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |   |   |  |  |  |
|  | c. <b>SMOKER</b><br>Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |   |   |  |  |  |
|  | d.   |   |   |  |  |  |  |  |   |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>CORONARY ARTERY DISEASE</b>  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  |  |   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |   |  |  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                |  |  |  |  |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Archana Sood MD.</b>  |   | 29c. License number<br><b>D41080</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>5/17/99</b>  |  |  |   |   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARCHANA SOOD, 104, PLUMTREE RD. BELAIR MD 21015</b>   |  |   |   |  |  |  |  |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br><b>P. Sparks</b>   |   |  |  |  |  |  |   |   |   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jackie R. Ellerbe

2. Date of Death

Month  
MAYDay  
16Year  
1999

3. Time of Death

1:56 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

458-52-5719

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 26, 1934

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

453 Retford Drive

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1955-5813. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Claims Adjuster

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Aurby Rayford Ellerbe

18. Mother's Name (First, Middle, Maiden Summa)

Leona Harrison

19a. Informant's Name/Relationship (Type, Print)

Mildred Ellerbe/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

453 Retford Dr., Severna Park, MD 21146

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lasta. Acute myocardial infarction  
Due to (or as a consequence of):b. Coronary artery Disease.  
Due to (or as a consequence of):c. Ischemic Cardiomyopathy.  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

3 days.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Depr Sided Pneumonia.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MD.

29c. License number

D45249.

29d. Date signed (Month, Day, Year)

MAY, 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSHEEL KUMAR SHARMA

SHEILA J. CRAN TOWERS. CRAN HIGHWAY  
GLEN BURNIE MD 21061.State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

ELLERBE, JACK  
Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

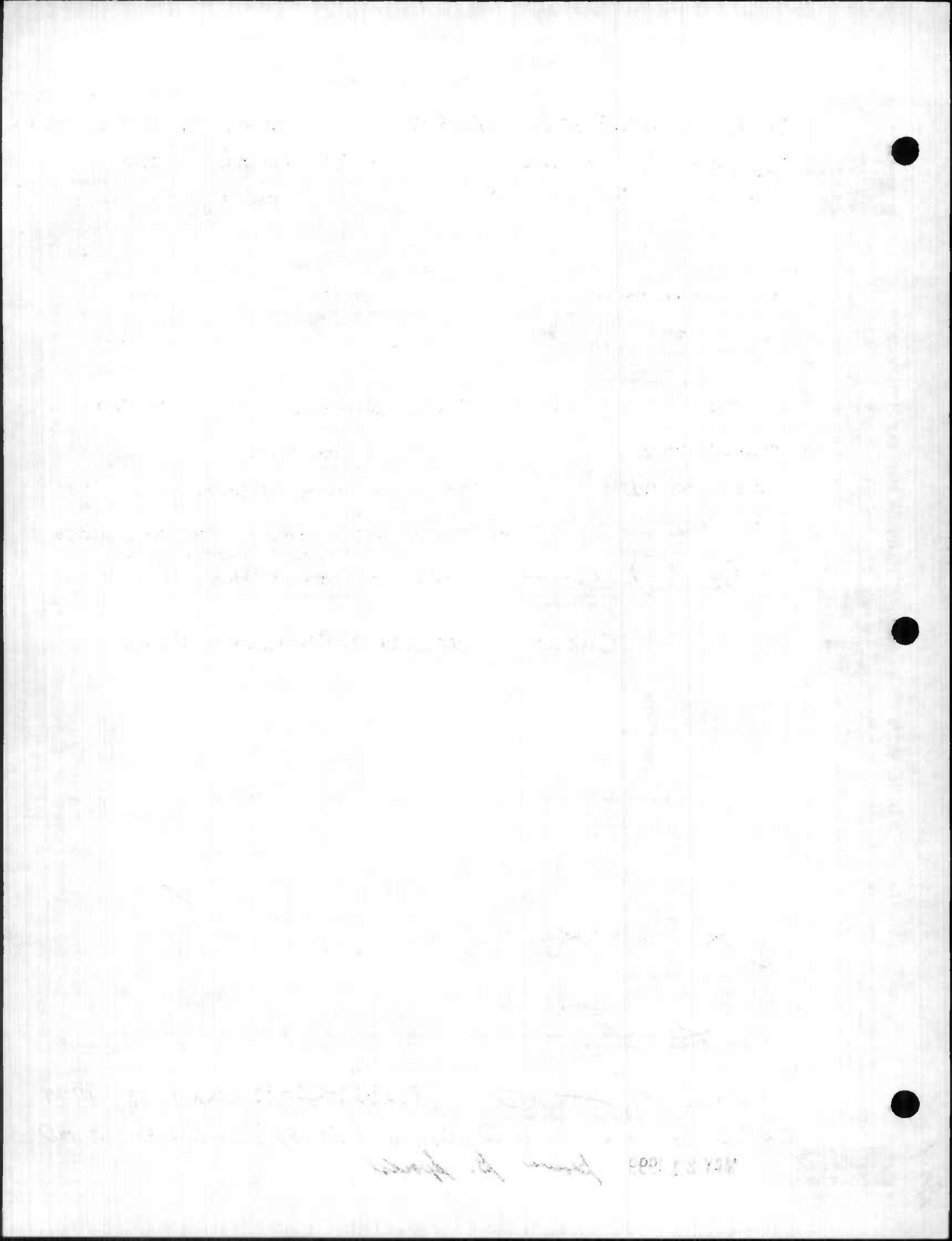
99 16334

|  |   |   |  |   |   |  |   |
|--|---|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PAUL LAWRENCE FIELDS</b>                 |   |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>18</b> Year <b>1999</b> |  | 3. Time of Death<br><b>12:05 AM</b>                         |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>SINAI HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>            |  | 4c. County of Death<br><b>N/A</b>                           |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-44-8827</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                      | 8. Date of Birth (Month, Day, Year)<br><b>May 01, 1947</b>   | 9. Birthplace (State or Foreign Country)<br><b>New York</b> |
|  | Usual Residence of Decedent   |   |  |   |   |  |   |
| 10a. State<br><b>MD.</b>   |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>4404 Wrenwood Avenue</b>  |   |   |  | 10f. Zip Code<br><b>21212</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dental Technician</b>   |   | 16b. Kind of Business/Industry<br><b>Dentistry</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Roosevelt Fields</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Fields</b>   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anita Fields (Wife)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4404 Wrenwood Avenue Baltimore, Maryland 21212</b>  |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>5/24/99 Baltimore, Maryland</b>  |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Caple Funeral Service</b><br><b>5502 Winner Avenue Baltimore, Maryland 21215</b>   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |   |   |  |   |   |  | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|  |   |   |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|  |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |   |   |  |   |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>P12339-CS-9211</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 18, 1999</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>CRAIG SINGER, MD. 2401 W. BELVEDERE, BALTIMORE MD</b>   |   |   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |   |  | 32. Registrar's Signature<br>   |   |  |   |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES LEE FOOR

2. Date of Death  
Month Day Year  
MAY 19, 19993. Time of Death  
2:00 PM

4a. Facility Name (If not institution, give street and number)

611 Park Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

Funeral  
Director

5. Social Security Number

170-26-1682

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 1, 1934

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

611 Park Avenue

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Data Processor

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

Cecil Warren Foor

18. Mother's Name (First, Middle, Maiden Surname)

LaDonna Grace Winck

19a. Informant's Name/Relationship (Type, Print)

Mark A. Foor (Nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2040 Putnam Road, Halethorpe, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Everett Cemetery

Date

5/22/99

20c. Location - City or Town, State

Everett, Pennsylvania

21. Signature of Funeral Service Licensee

Jackie D. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME

4107 Wilkens Avenue

Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sonya Lecuona MD

29c. License number

D 50847

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sonya Lecuona

315

N. Calvert St

Baltimore MD 21202

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16336

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nettie Mae Ford

2. Date of Death

Month  
MayDay  
18Year  
1999

3. Time of Death

10:00 am

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

216-44-7757

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 8, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5085 Solomons Island Road

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Post Master

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Mervin Norfolk

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Norfolk

19a. Informant's Name/Relationship (Type, Print)

Ann King (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5931 Fishers Road, Lothian, MD 20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. James Cemetery

Date

05/20

20c. Location - City or Town, State

Lothian, MD

21. Signature of Funeral Service Licensee

B. J. ...

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 wk

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Severe Generalized Atherosclerosis

Due to (or as a consequence of):

Years

c. Type 2 - Diabetes Mellitus

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia - bacterial

Ischemic bowel disease

CVA - Cerebral Infarction

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joseph N. Friend M.D.

29c. License number

D17965

29d. Date signed (Month, Day, Year)

5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph N. Friend 205 Ridgely Ave Annapolis, MD 21401

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

J. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16337

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL AUGUSTINE GARRETT II</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MAY 20, 1999</b>   |  | 3. Time of Death<br><b>12:00 NOON</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>8205 BAYSIDE DRIVE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>PASADENA</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-38-4328</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 12, 1939</b>                          |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>PASADENA</b>                                       |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>8205 BAYSIDE DRIVE</b>   |  | 10f. Zip Code<br><b>21122</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FBI AGENT</b>                         |  | 16b. Kind of Business/Industry<br><b>U.S. GOVERNMENT</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ROBERT B. GARRETT SR.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>NELLE NETHKEN</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JANE G. NOLAN (SISTER)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18 HILLCREST DRIVE, DEER PARK, MD. 21550</b>  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER, LLC</b>                                     |  | 20c. Location - City or Town, State<br><b>STEVENSVILLE, MD.</b>   |  | 20d. Date<br><b>5/21/99</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael C. Sullivan</i>   |  |   |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Metastatic Rectal Adenocarcinoma two years</b><br>Due to (or as a consequence of):<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b>                |  |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                             |   |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br><i>Marshall A. Levine M.D.</i>   |  |   |  | 29c. License number<br><b>D17873</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 21, 1999</b>                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marshall A. Levine 1838 Greene Tree Road Suite 120 B. H. Moore, MD 21208</b> |   |  |   |  |   |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |   |  | 32. Registrar's Signature<br><i>Benjamin B. Sparks</i>  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 16338

|  |   |  |  |  |  |   |  |  |
|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>TED GODDARD</b>                                |  |  |  | 2. Date of Death<br>Month <b>05</b> Day <b>18</b> Year <b>1999</b> |   | 3. Time of Death<br><b>9:50AM</b>                            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>           |   | 4c. County of Death<br><b>N/A</b>                            |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>543-36-3156</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.                   |   | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 30, 1931</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>OREGON</b>                                     |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>              |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>1411 WEST BALTIMORE STREET</b>  |  | 10f. Zip Code<br><b>21223</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>TO 1956</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH GRADE</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TELEVISION REPAIRS</b>   |  | 16b. Kind of Business/Industry<br><b>OWNER</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>FRANK GODDARD</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HAZEL T. CHAMPION</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>TED DAVID GODDARD, II</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>456 OELLA AVENUE - ELICOTT CITY, MARYLAND 21043</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY, INC.</b>   |   | 20c. Date<br><b>5/22/99</b>  |  | 20d. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Quanta R Thomas</b>   |  |  |
| 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME, INC.</b>  |   | 23a. Particular the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic lung cancer</b>                                    |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  | 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>Anuradha Reddy</b>   |  | 29c. License number<br><b>D46305</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/18/99</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>ANURADHA REDDY</b>  |   | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br><b>B. Sparks</b>  |  | 33. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>530 N. Hilton Street Baltimore MD 21229</b>  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

9 16339

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |   |  |  |  |  |   |  |  |
|--|--|---|--|---|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Thelma M. Gibbs</b>   |  |   |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>18</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>4:10 P.M.</b>   |   |  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b>  |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  |  |   | 4c. County of Death<br><b>Anne Arundel</b>                     |  |
| 5. Social Security Number<br><b>215-28-8640</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 8, 1931</b>     |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |   |  |  |  |  |   |  |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Pasadena</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>175 Magothy Beach Road</b>  |  |   |  |   |  | 10f. Zip Code<br><b>21122</b>  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>            |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>N/A</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Anson S. Gibbs, Sr.</b>  |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Waltman</b>  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosie L. Gibbs (Sister)</b>   |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>175 Magothy Beach Rd. Pasadena, Maryland 21122</b> |  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>   |  |  |  | 20c. Date<br><b>5/22/99</b>  |   | 20d. Location - City or Town, State<br><b>Glen Burnie, Md.</b> |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  |   |  | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home P.A.<br/>3204 Mountain Rd. Pasadena, Maryland 21122</b>                           |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MALIGNANT ARRHYTHMIA</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c. CHRONIC RENAL FAILURE.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |   |  |  |  |  |   |  |  |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b>        |  |   |  |   |  |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred                              |  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  |   |  |   |  | 29c. License number<br><b>043977</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 18 1999</b> |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Angien Driscoll, 301 Hospital Dr., Glen Burnie, MD. 21061</b>   |  |   |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |   |  |   |  | 32. Registrar's Signature<br>  |  |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

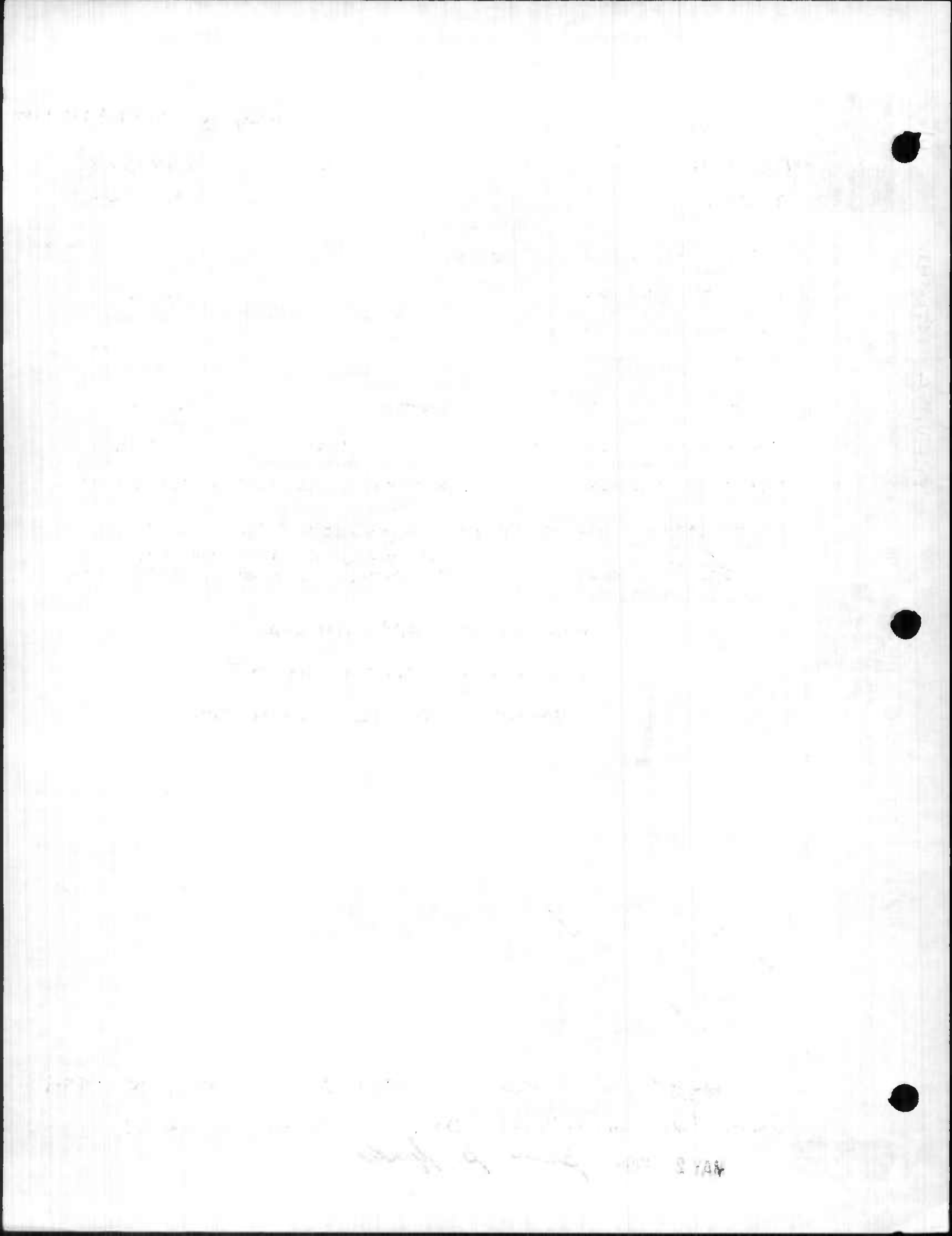
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Baltimore, Maryland 21215-0020

THELMA GIBBS





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |  |  |  |  |  |   |   |  |   |  |
|---|--|--|--|--|--|--|---|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DONALD RAY GARLAND</b>   |  |  |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>17</b> Year <b>1999</b>  |   | 3. Time of Death<br><b>06:00 AM</b>   |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>   |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>N/A</b>   |  |   |  |
| 5. Social Security Number<br><b>218-30-6619</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 6, 1934</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| Usual Residence of Decedent   |  |  |  |  |  |  |   |   |  |   |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| 10e. Street and Number<br><b>406 Cambria Street</b>   |  |  |  | 10f. Zip Code<br><b>21225</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1956-57</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b>0</b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer/Mechanic</b>  |  |  | 16b. Kind of Business/Industry<br><b>Chesapeake Box Company</b>         |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John William Garland</b>  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Mae Kave</b>  |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Stephella M. Garland ( Wife )</b>  |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4709 Pennington Avenue Baltimore, Maryland 21226</b> |   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>  |  | Date<br><b>5/20/99</b>   |   | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |  |  |  | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home P.A.<br/>237 E. Patapsco Avenue Baltimore, Maryland 21225</b>                       |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  |  |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>5 months</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RESPIRATORY Failure, PNEUMONIA</b><br><b>HYPERCALCEMIA</b>   |  |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>                                     |  | 29c. License number<br><b>P10643</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 17 1999</b>  |   |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANTHONY PETER DASARO MD 3001 South Hanover Street BALTIMORE MARYLAND</b>   |  |  |  |  |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |  |  | 32. Registrar's Signature<br>  |  |  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

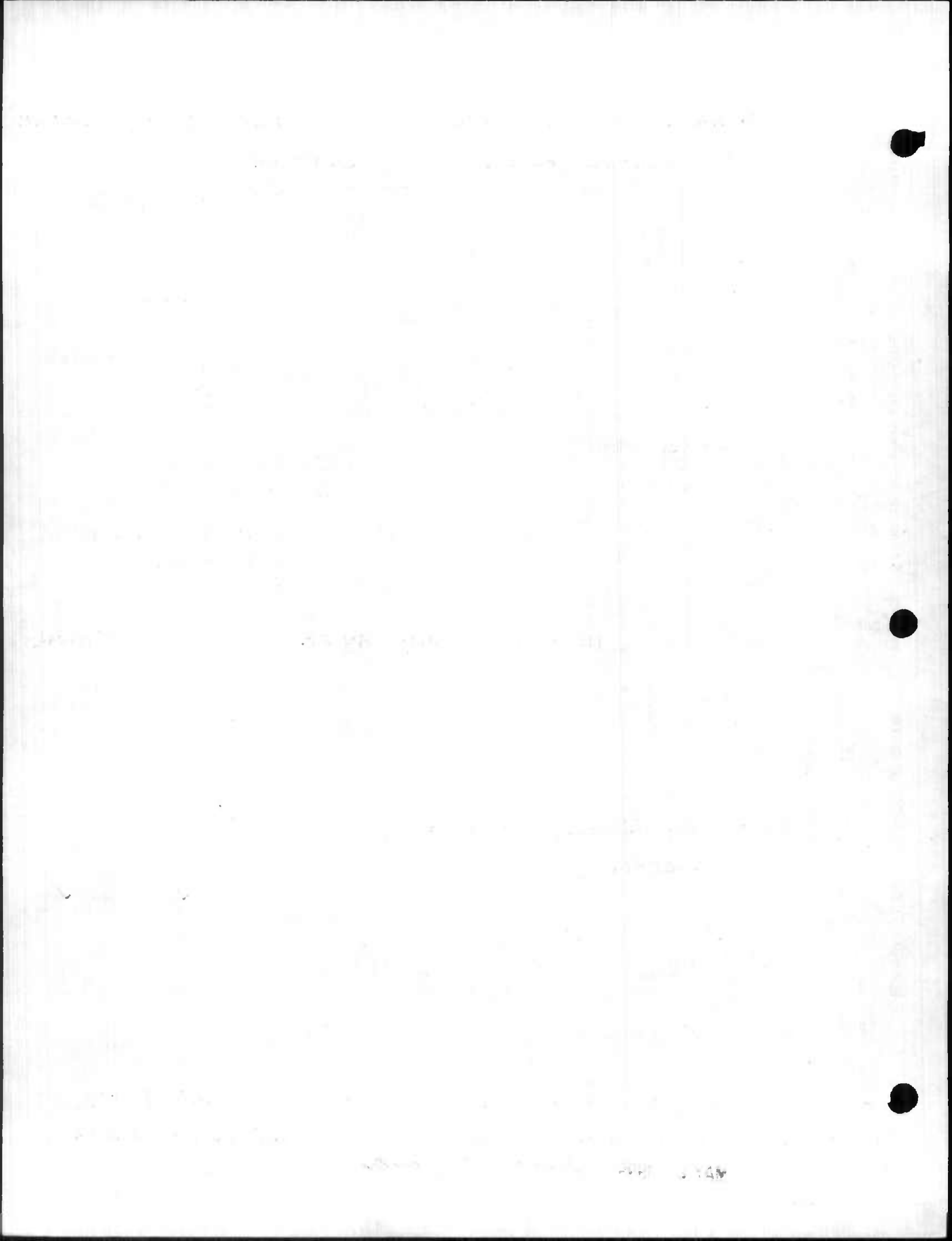
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anastasia E. Goralski

2. Date of Death

May 19, 1999

3. Time of Death

5:10 p.m.

4a. Facility Name (If not Institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-80-1380

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 2, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

248 S. Wolfe

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

John Gross

18. Mother's Name (First, Middle, Maiden Surname)

Frances Peters

19a. Informant's Name/Relationship (Type, Print)

Philip Goralski/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

248 S. Wolfe St. Baltimore, Maryland 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore National

Date

5/24/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

David J. Weber

22. Name and Address of Facility

David J. Weber Funeral Homes, P.A.

401 S. Chester St. Baltimore, Maryland 21231

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Lung Cancer

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Atherosclerotic Coronary Vascular

Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Pallen M.D.

29c. License number

P12673

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pallen M.D. 60 Maryland General Hospital

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Anna P. Sparks

State Registrar

MAY 21 1999

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

ANNA GORALSKI



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16342

AMENDED #7 PER FH G771 5/21/99 AH

|  |   |  |   |  |   |  |  |  |
|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH GILBERT</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>05/17/1999</b>   |  | 3. Time of Death<br><b>11:15 a.m.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>218 Rosewood Avenue</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-24-0813</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>2/25/28</b>  |  |
|  | 10a. State<br><b>Md</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Catonsville</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>218 Rosewood Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21228</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John J. Nolan, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Bannon</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine Izzo/Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>218 Rosewood Avenue, Baltimore, Md. 21228</b>   |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet. Cem</b>   |  | Date<br><b>5/21/99</b>  |  | 20c. Location - City or Town, State<br><b>Owings Mills, Md</b>                                 |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Mark Marshall</b>   |  |   |  | 22. Name and Address of Facility<br><b>Sterling-Ashton-Schwab Funeral Home, Inc<br/>736 Edmondson Avenue, Baltimore, Md. 21228</b>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Lung cancer, progressive</b><br>Due to (or as a consequence of):<br><b>b. radiation pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |   |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred   |  |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |   |  |  |  |
| State Registrar  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |  |  |
|  | 29b. Signature and Title of certifier<br><b>ARIF H. VESAIN</b>  |  |   |  | 29c. License number<br><b>033759</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/18/99</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARIF H. VESAIN</b>   |  |   |  |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |   |  |   |  |  |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16343

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES HOWARD KREIDER, JR.</b>             |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>19</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>5:00 AM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>103 M STREET S.E.</b> |   | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-12-4045</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 7, 1918</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |
| Usual Residence of Decedent   |  |   |  |  |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>103 M STREET S.E.</b>  |  |   | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-1945</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MECHANIC</b>                       |  | 16b. Kind of Business/Industry<br><b>DOVELL / WILLIAMS</b>   |
| 17. Father's Name (First, Middle, Last)<br><b>CHARLES H. KREIDER, SR.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY BOWMAN</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DAISY E. KREIDER (WIFE)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>103 M STREET, S.E., GLEN BURNIE, MD. 21061</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>   |  | Date<br><b>5/21/99</b>   | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD. 21061</b>   |
| 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                         |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PARKINSONS DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. TYPE II DIABETES MELLITUS</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |  |   |  |  | Approximate Interval Between Onset and Death<br><b>YEARS</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ANNE FIBRILLATION</b><br><b>TYPE II DIABETES MELLITUS</b>  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 28d. Describe how Injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>019991</b>   | 29d. Date signed (Month, Day, Year)<br><b>5-19-99</b>  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DANIEL RICE, M.D., Suite 500 2001 Hospital Drive Glen Burnie Maryland 21061</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16344

|  |   |   |   |   |  |   |  |  |
|--|---|---|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>OLA m HINES</b>                                  |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>14th</b> Year <b>1999</b>  |   | 3. Time of Death<br><b>5:30 Am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Liberty Medical Center</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-18-9919</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>03-20-11</b>   | 9. Birthplace (State or Foreign Country)<br><b>SC</b>  |
|  | Usual Residence of Decedent   |   |   |   |  |   |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>NA</b>                                    |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2303 Ashburton Street</b>   |   |   |   | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b> College (1-4 or 5+) <b>NA</b>  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Stamper</b>   |  | 16b. Kind of Business/Industry<br><b>Continental Can</b>                                    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Hector Morris</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Ella McCall</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Beatrice Ward</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21133 9931 Hoyt Circle Randallstown, Maryland</b>  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery</b>   |   | Date<br><b>05-19-99</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                    |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>   |  |   |  |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Anemia</b><br>Due to (or as a consequence of):<br><b>Cardiac arrhythmia</b> |   |   |   |   |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hip Fracture</b>  |   |   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>04-30-1999</b> |   | 28b. Time of Injury<br><b>unknown AM</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>Subject fell at home</b>   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>2303 Ashburton St. Baltimore, Maryland</b>   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |   | 29b. Signature and title of certifier<br><b>Terence J. Lamb MD</b>  |  | 29c. License number<br><b>D37203</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 14th 1999</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Terence J. Lamb MD Liberty Medical Center Baltimore MD 21215</b>  |   |   |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16345

|  |   |   |  |   |   |  |  |  |
|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert M. Hair</b>                                 |   |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>16</b> Year <b>1999</b> |  | 3. Time of Death<br><b>2:05 A.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Laurel</b>               |  | 4c. County of Death<br><b>Prince George</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>058-01-5447</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.                                 | 8. Date of Birth (Month, Day, Year)<br><b>July 21, 1916</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |
|  | Usual Residence of Decedent   |   |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>Laurel</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>9260 Cherry Lane Unit #33</b>   |   |   |  | 10f. Zip Code<br><b>20708</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chief Warrant Officer</b>   |   |  | 16b. Kind of Business/Industry<br><b>US Army</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Matthew Hair</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie Gunther</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Hair/Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9260 Cherry Lane Unit #33, Laurel, MD 20708</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr.</b>   |   | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b> |  |  |
| 21. Signature of Funeral Service Licensee<br><i>James Allen</i>  |   |   |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road, Laurel, Maryland 20707</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death<br><b>48 hours</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                                |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred                              |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  | 29b. Signature and title of certifier<br><i>James V. Fotherman</i>  |   | 29c. License number<br><b>025136</b>                           |  | 29d. Date signed (Month, Day, Year)<br><b>May 16, 1999</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>14201 Laurel Park Drive, Suite 102-A, Laurel, Maryland 20707</b>  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |   |  | 32. Registrar's Signature<br><i>James B. Sparks</i>   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16346

|  |   |   |  |  |   |  |  |   |
|--|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Alfred Hines</u>                                     |   |  |  | 2. Date of Death<br>Month <u>May</u> Day <u>19</u> Year <u>1999</u> |  | 3. Time of Death<br><u>8:44 pm</u>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Sinai Hospital - Baltimore</u> |   |  |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>            |  | 4c. County of Death  |   |
| Funeral<br>Director  | 5. Social Security Number<br><u>230-05-6069</u>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>79</u> Yrs.   | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><u>11 27 19</u>  | 9. Birthplace (State or Foreign Country)<br><u>V.A.</u>                                   |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><u>MD</u>  |   | 10b. County<br><u>NA</u>  |  | 10c. City, Town or Location<br><u>Baltimore</u>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10e. Street and Number<br><u>3904 Dolfield Ave</u>   |   |   |  | 10f. Zip Code<br><u>21215</u>  |   | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12th grade</u><br>College (1-4 or 5+) <u>na</u>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Laborer</u>  |   | 16b. Kind of Business/Industry<br><u>Bethlehem Steel</u>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><u>Albert Hines</u>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><u>Aretta Epps</u>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Charles E. Hines-Son</u>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3904 Dolfield Ave, Baltimore Md 21215</u>  |   |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Woodlawn Cemetery</u>  |  | Data<br><u>5/24/99</u>   |   | 20c. Location - City or Town, State<br><u>Baltimore Co., Md</u>  |  |   |
| 21. Signature of Funeral Service Licensee<br><u>Gladys W. [Signature]</u>  |   |   |  | 22. Name and Address of Facility<br><u>March F/H West</u><br><u>4300 Wabash Ave, Baltimore Md 21215</u>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Pneumothorax</u><br>Due to (or as a consequence of):<br><br>b. <u>Emphysematous Blebs</u><br>Due to (or as a consequence of):<br><br>c. <u>Chronic Obstructive Pulmonary Disease</u><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><u>1 week</u><br><br><br><br><u>years</u> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Congestive Heart Failure</u>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |
|  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br><u>[Signature]</u>  |   |   |  | 29c. License number<br><u>RES-000</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>May 19, 1999</u>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Amador Subong, Sinai Hospital - Baltimore, 2401 W. Belvedere Avenue, Baltimore MD 21215</u>   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><u>MAY 21 1999</u>  |   | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-16347

|   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>BEATRICE LOUISE HUBBARD                      |   |  |   | 2. Date of Death<br>Month Day Year<br>MAY 14 1999   |  | 3. Time of Death<br>12:50 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>North Arundel Hospital |   |  |   | 4b. City, Town, or Location of Death<br>Glen Burnie |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-14-8332   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>79 Yrs.   | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Mar 22, 1920  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland                                     |   |  |   |   |  |  |  |
| Usual Residence of Decedent   |  |   |  |   |   |  |  |  |
| 10a. State<br>Md.   |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Pasadena   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>358 Riverside Drive   |  |   |  | 10f. Zip Code<br>21122  |   | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 0  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary Of Claims Co.  |   |  | 16b. Kind of Business/Industry<br>Maryland Casualty Insurance                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Alwood Shrieves  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen (Unknown)  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>William M. Holman, Jr. -Grandson  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>211 Blenheim Rd., Baltimore, Md. 21212   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lorraine Park Cemetery  |   | 20c. Location - City or Town, State<br>May 18, 1999 Balto., Md.  |  |  |
| 21. Signature of Funeral Service Licensee<br>Kevin E. Ecker   |  |   |  | 22. Name and Address of Facility<br>McCully-Polyniak Funeral Home, P.A.<br>3204 Mountain Rd., Pasadena, Md. 21122   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. BOWEL INFARCTION<br>Due to (or as a consequence of):<br>b. SEPTIC SHOCK<br>Due to (or as a consequence of):<br>c. ACUTE RENAL FAILURE.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|   |  |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|   |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred            |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]  |  |   |  | 29c. License number<br>D43977   |   |  | 29d. Date signed (Month, Day, Year)<br>May 14 1999   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>Agnes O. [Signature] 31 Hospital Drive, Glen Burnie, MD, 21061  |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |  |   |  | 32. Registrar's Signature<br>[Signature]  |   |  |  |  |

Beatrice Hubbard  
Baltimore, Maryland 21215-0020

all

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report is a general description of the project and its objectives. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief history of the project and a statement of the problem being addressed.

2. The second part of the report is a detailed description of the methodology used in the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the data collection process and the statistical methods used to analyze the data.

3. The third part of the report is a discussion of the results of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

4. The fourth part of the report is a conclusion and a statement of the limitations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

5. The fifth part of the report is a bibliography of the sources used in the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

6. The sixth part of the report is an appendix containing the raw data and the statistical analysis. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

7. The seventh part of the report is a summary of the findings and a statement of the conclusions drawn from the data. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

8. The eighth part of the report is a statement of the limitations of the study. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

9. The ninth part of the report is a statement of the conclusions drawn from the data. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

10. The tenth part of the report is a statement of the findings and a statement of the conclusions drawn from the data. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

11. The eleventh part of the report is a statement of the conclusions drawn from the data. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief description of the findings and a statement of the conclusions drawn from the data.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#10b,10c eprFHG782 4/5/2000 EW

## Certificate of Death

Reg. No.

16348

|  |  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
|--|--|---|--|--|---|--|---|---|--|---|-----------------------------------|---------------------------------------|-------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES EARL HENNLEIN</b>                             |   |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>18</b> Year <b>1999</b> |  | 3. Time of Death<br><b>0110</b>                             |   |  |   |                                   |                                       |                                     |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Fallston General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Fallston</b>             |  | 4c. County of Death<br><b>Harford</b>                       |   |  |   |                                   |                                       |                                     |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-01-5431</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 24, 1908</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |                                   |                                       |                                     |
|  | Usual Residence of Decedent  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Harford</b>   |  | 10c. City, Town or Location<br><b>Harford</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |                                   |                                       |                                     |
| 10e. Street and Number<br><b>4830 Norrisville Rd.</b>  |  |   |  | 10f. Zip Code<br><b>21161</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |   |                                   |                                       |                                     |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW 11</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |   |                                   |                                       |                                     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4or 5+) <b>N/A</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Postal Maintenance</b>   |   | 16b. Kind of Business/Industry<br><b>U.S. Postal Service</b>   |   |   |  |   |                                   |                                       |                                     |
| 17. Father's Name (First, Middle, Last)<br><b>Jacob Hennlein</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Foley</b>  |   |  |   |   |  |   |                                   |                                       |                                     |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Wayne R. Hennlein, Sr.</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4830 Norrisville Rd. White Hall, Md. 21161</b>   |   |  |   |   |  |   |                                   |                                       |                                     |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery</b>  |  | Date<br><b>5-21-1999</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |   |   |  |   |                                   |                                       |                                     |
| 21. Signature of Funeral Service Licensee<br><i>Donald C. Shuster</i>  |  |   |  | 22. Name and Address of Facility<br><b>Lassahn Funeral Home</b><br><b>7401 Belair Rd. Baltimore, Md. 21236</b>   |   |  |   |   |  |   |                                   |                                       |                                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <i>Congestive heart failure and Chronic Respiratory weeks</i></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/>           years<br/>years<br/>years         </td> </tr> <tr> <td>b. <i>End-stage Renal Disease</i></td> </tr> <tr> <td>c. <i>Peripheral Vascular disease</i></td> </tr> <tr> <td>d. <i>Type II diabetes mellitus</i></td> </tr> </table> |  |   |  |  |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <i>Congestive heart failure and Chronic Respiratory weeks</i> | Approximate Interval Between Onset and Death<br><br>years<br>years<br>years | b. <i>End-stage Renal Disease</i> | c. <i>Peripheral Vascular disease</i> | d. <i>Type II diabetes mellitus</i> |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <i>Congestive heart failure and Chronic Respiratory weeks</i>                                   | Approximate Interval Between Onset and Death<br><br>years<br>years<br>years   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
|  | b. <i>End-stage Renal Disease</i>  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
|  | c. <i>Peripheral Vascular disease</i>  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
|  | d. <i>Type II diabetes mellitus</i>  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |   |                                   |                                       |                                     |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |                                   |                                       |                                     |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |   |                                   |                                       |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |   |                                   |                                       |                                     |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |   |  |   |   |  |   |                                   |                                       |                                     |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
| 29b. Signature and title of certifier<br><i>Albert S.C. Sun, M.D.</i>  |  |   |  | 29c. License number<br><b>D-18779</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 18, 1999</b>   |   |   |  |   |                                   |                                       |                                     |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Albert S.C. SUN, M.D. 1800 Harford Road, Fallston, MD 21047</b>   |  |   |  |  |   |  |   |   |  |   |                                   |                                       |                                     |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |   |   |  |   |                                   |                                       |                                     |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: #7 PER A.B G772 6-1-99 WR.

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Harry L. Hunter</b>                             |   |  |   | 2. Date of Death<br>Month Day Year<br><b>May 15, 1999</b>      |  | 3. Time of Death<br><b>0558</b>                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>The Memorial Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Easton</b>          |  | 4c. County of Death<br><b>Talbot</b>                      |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-07-6392</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>81</b> <del>88</del> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>May 9, 1918</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Colorado</b>                                    |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Talbot</b>                                   |  | 10c. City, Town or Location<br><b>Easton</b>              |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>29595 Dutchmans Lane, Bldg. 801</b>  |  | 10f. Zip Code<br><b>21601</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Purchasing Officer</b>  |  | 16b. Kind of Business/Industry<br><b>Library</b>  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Jasper Lenor Hunter</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Minnie Ella Peterson</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mysie M. Hunter/wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29595 Dutchmans Lane, Bldg. 801, Easton, MD 21601</b>                                       |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Date</b>   |  | 20c. Location - City or Town, State   |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>   |  |   |  | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, MD 21201</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)  |  | a. <b>Pancreatic Carcinoma</b>  |  |   |  | Months   |   |  |
|  |  | Due to (or as a consequence of):  |  |   |  |  |   |  |
|  |  | b. <b>Hypertension</b>  |  |   |  |  |   |  |
|  |  | Due to (or as a consequence of):  |  |   |  |  |   |  |
|  |  | c.  |  |   |  |  |   |  |
|  |  | Due to (or as a consequence of):  |  |   |  |  |   |  |
|  |  | d.  |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Hung Tran Davis, MD</b>   |  | 29c. License number<br><b>053111</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/15/99</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>HUNG TRAN DAVIS THE MEMORIAL HOSPITAL EASTON, MARYLAND</b>  |  |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br><b>Beverly B. Sparks</b>   |  |   |  |  |   |  |

Harry Lenor Hunter

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16350

|   |   |  |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>James JOHNSON</i>                                |  |  |  | 2. Date of Death<br>Month Day Year<br><i>May 19, 99</i>  |  | 3. Time of Death<br><i>2:35pm</i>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Joseph Ritchey Hospice</i> |  |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i> |  | 4c. County of Death<br><i>NA</i>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>457-40-8489</i>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>66</i> Yrs.   | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>10-12-32</i>   | 9. Birthplace (State or Foreign Country)<br><i>TX</i>                               |  |
|   | Usual Residence of Decedent   |  |  |  |  |  |  |   |  |
| 10a. State<br><i>MD</i>   |   | 10b. County<br><i>NA</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><i>1029 Comet Street</i>  |   |  |  | 10f. Zip Code<br><i>21202</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>10th Grade</i><br>College (1-4or 5+) <i>NA</i>  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Construction worker</i>  |  |  | 16b. Kind of Business/Industry<br><i>Mahoney &amp; Son</i>                                     |   |  |
| 17. Father's Name (First, Middle, Last)<br><i>Hogan Johnson</i>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Rosalee Johnson</i>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Roselie R. Robinson</i>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>21213 2836 Clifton Park Terrace Baltimore, MD</i>  |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Voshell Mem. Gardens</i>  |  | Data<br><i>05-24-99</i>  |  | 20c. Location - City or Town, State<br><i>Dundalk, MD</i>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |  |  | 22. Name and Address of Facility<br><i>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</i>  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Terminal respiratory failure</i><br>Due to (or as a consequence of):<br><br><i>b. Non-small cell carcinoma of the @lower lobe of lung</i><br>Due to (or as a consequence of):<br><br><i>c.</i><br>Due to (or as a consequence of):<br><br><i>d.</i> |   |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>Hours</i><br><br><i>6 months</i> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Alcoholism</i>   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i> |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  | 29c. License number<br><i>DO2175</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>5-19-99</i>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Rolfe B. FIRM 8826 Winands Road Randallstown, MD 21133</i>   |   |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>MAY 6 1999</i>  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|  |   |                               |  |  |  |  |  |  |
|--|---|-------------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Samuel Lee James JR.</b>   |                               |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>19</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>08:14</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |                               |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>248-60-3287</b>   |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>02/17/1942</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>   |                               | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                               | 10e. Street and Number<br><b>3610 EDGE GREEN AVE.</b>  |  | 10f. Zip Code<br><b>21211</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>MINISTER</b>   |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLERGYMAN</b>  |  | 16b. Kind of Business/Industry   |  | 17. Father's Name (First, Middle, Last)<br><b>SAMUEL LEE JAMES SR.</b>   |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELOUISE DAVIS</b>   |                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>MATILDA JAMES / WIFE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3610 EDGE GREEN AVE, BALTIMORE, MD. 21211</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| Physician<br>/Medical<br>Examiner  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |                               | 20c. Date<br><b>5/24/99</b>  |  | 20d. Location - City or Town, State<br><b>LANDSDOWNE, MARYLAND</b>   |  | 21. Signature of Funeral Service Licensee<br>  |  |
|  | 22. Name and Address of Facility<br><b>THE DERRICK C. JONES FUNERAL HOME 4611 PARK HEIGHTS AVE BALTIMORE, MARYLAND 21215</b>  |                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hemorrhage</b><br>Due to (or as a consequence of):<br><b>b. Coagulopathy</b><br>Due to (or as a consequence of):<br><b>c. Hepatic Cirrhosis</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>2 weeks</b><br><b>1 year</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 23c. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| State Registrar  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                               | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|  | 29b. Signature and title of certifier<br><b>Dr. M. J. Jones, MD</b>   |                               | 29c. License number<br><b>RES-000</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 19, 1999</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mark Mofid 600 North Wolfe Street Baltimore, MD 21287-9106</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>                      |   | 32. Registrar's Signature<br> |  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16352

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Laura Josephine Kerr

2. Date of Death

May 20, 1999

3. Time of Death

12:45 P.M.

4a. Facility Name (If not institution, give street and number)

Frederick Villa Nursing Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-40-4375

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 20, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1220 Glenback Avenue

10f. Zip Code

21208

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harvey Arnold

18. Mother's Name (First, Middle, Maiden Surname)

Stella Lynch

19a. Informant's Name/Relationship (Type, Print)

Thomas M. Kerr, Sr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Hickory Ridge Court; Baltimore, Maryland 21228

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Balto. Washington Crem 5/22/99

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road; Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bronchopneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Two Weeks.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia

Osteoarthritis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30469.

29d. Date signed (Month, Day, Year)

May 21, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N B Vellanki, 9055, Chevrolet Drive #100, Ellicott City, MD 21042.

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

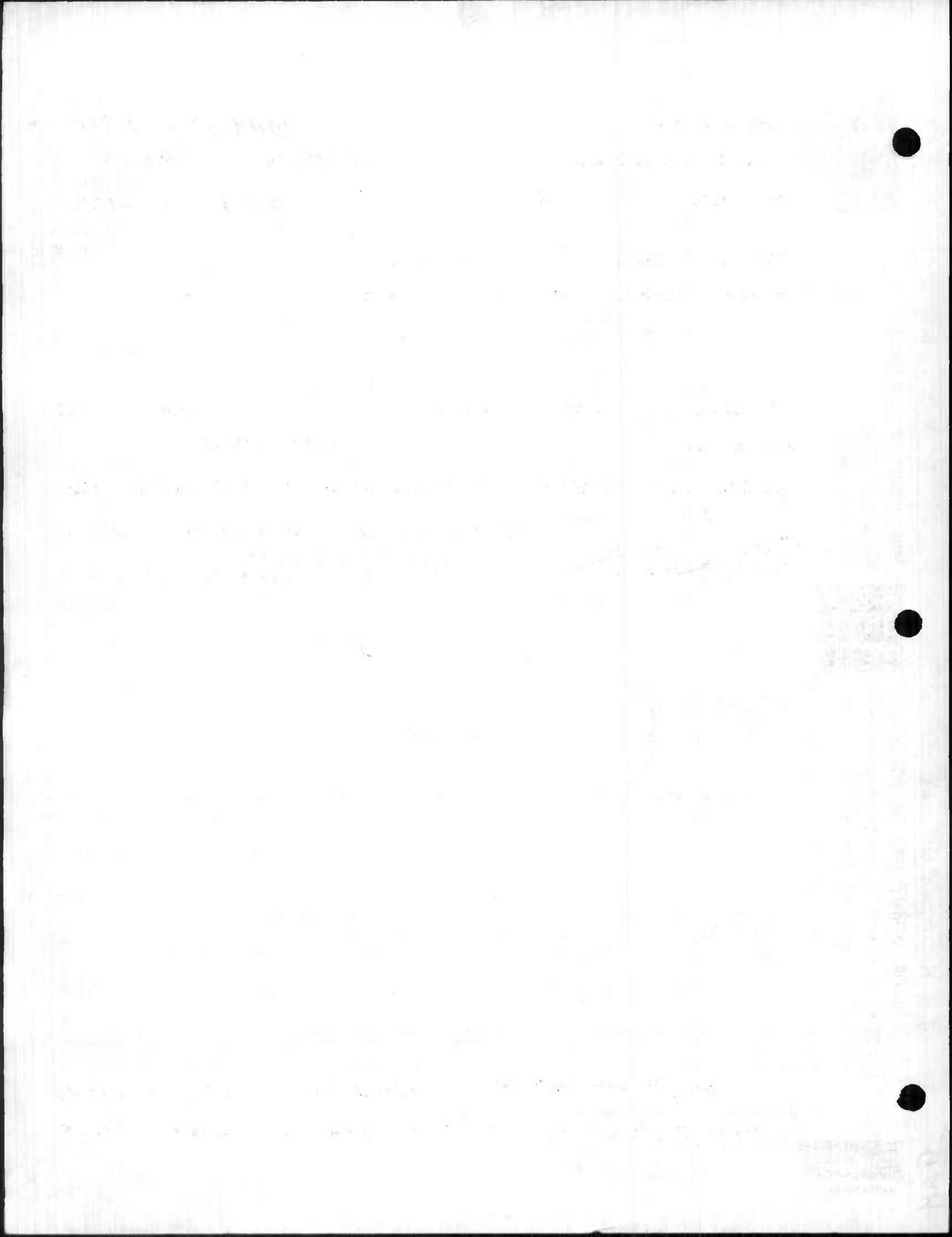
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16353

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM F. KOPF</b>   |  |   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>13</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>06:30 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CHARLESTOWN CARE CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CATONSVILLE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>119-22-6128</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 15, 1902</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>CATONSVILLE</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 10e. Street and Number<br><b>701 MAIDEN CHOICE LANE -APT-1303</b>  |  |   |  |
|   | 10f. Zip Code<br><b>21228</b>  |  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>6 YRS</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ENGINEER</b>                      |  | 16b. Kind of Business/Industry<br><b>MECHANICAL DESIGN</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>JOHN G. KOPF</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALBERTINA LUHRS VADERSON</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ELIZABETH A. KOPF (DAUGHTER)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3102 TYNDAL AVENUE - BALTIMORE, MARYLAND 21214</b>                                       |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY, INC.</b>  |  | Date<br><b>5/17/99</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>HUBBARD FUNERAL HOME, INC.</b><br><b>4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229</b>                     |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. Multi infarct dementia</b><br>Due to (or as a consequence of):  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>10 yrs</b>   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b>   |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |
|   |  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D34053</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 15, 1999</b>  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gary Applebaum MD 711 Maiden Choice Lane 21228</b>  |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item #26 per Dr g771 5/21/99 gap

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Knighton

2. Date of Death

May 13, 1999

3. Time of Death

6:10 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

2213 Holly Neck Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

235-12-1372

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03/ 04/ 1918

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2035 Fleet Street

10f. Zip Code

21231

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Charles

Beard

18. Mother's Name (First, Middle, Maiden Surname)

Lottie

Greenfield

19a. Informant's Name/Relationship (Type, Print)

Brian Knighton/grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2035 Fleet Street Baltimore Maryland 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tuscoroa Cemetery

Date

20c. Location - City or Town, State

May 17 Martinsburg, W. Virginia

21. Signature of Funeral Service Licensee

Kathleen A. Weber CFSP

22. Name and Address of Facility

David J. Weber Funeral Homes, PA

401 S. Chester St. Baltimore Maryland 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Terminal Cancer of the lung

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Sajadi MD

29c. License number

D18951

29d. Date signed (Month, Day, Year)

5-14-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

REZA SAJADI 98 North Broadway Baltimore 21231

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16355

May 17, 1999 8:10 a.m.

Baltimore, Maryland 21215-0020

Elizabeth Konig

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerPhysician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |  |  |   |
|--|--|---|--|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br>Elizabeth J. Konig   |  | 2. Date of Death<br>Month Day Year<br>May 17, 1999  |  | 3. Time of Death<br>8:10 AM  |  |   |
| 4a. Facility Name (If not institution, give street and number)<br>Stella Maris Hospice   |  | 4b. City, Town, or Location of Death<br>Towson  |  | 4c. County of Death<br>Baltimore   |  |   |
| 5. Social Security Number<br>220-22-7180   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>86 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Jan. 27, 1913 | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |
| Usual Residence of Decedent  |  |   |  |  |  |   |
| 10a. State<br>Maryland   | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Nottingham   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |
| 10e. Street and Number<br>7 Bothwell Garth   |  | 10f. Zip Code<br>21236  |  | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2 Years   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Manager   |  |   |
| 16b. Kind of Business/Industry<br>Restaurant   |  | 17. Father's Name (First, Middle, Last)<br>John Johnson   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lyda (Not Known)  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Jack O'Laughlin/Son  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 Bothwell Garth Baltimore, Maryland 21236   |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Mem. Gdn.  |  | 20c. Date<br>5/22/99   |  |   |
| 20d. Location - City or Town, State<br>Timonium, Maryland  |  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. End-Stage Dementia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D43725   |  | 29d. Date signed (Month, Day, Year)<br>5/18/99   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Tariq Mahmood, 2300 Dulaney Valley Rd., Timonium, MD 21093   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999   |  | 32. Registrar's Signature<br>   |  |  |  |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16356

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |                                |  |  |
|--|--|---|--|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Virginia Klimas</b>   |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>17</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>10:24 Pm</b>  |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |                                | 4c. County of Death<br><b>Baltimore</b>  |  |
| 5. Social Security Number<br><b>216-32-1012</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>March 12 1935 VA</b>   |  |
| Usual Residence of Decedent  |  |   |  |  |                                |  |  |
| 10e. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>1525 Aldeney Ave</b>  |  |   |  | 10f. Zip Code<br><b>21220</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Marriad <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b>  |  | College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembly Line Worker</b>   |                                | 16b. Kind of Business/Industry<br><b>Medical Equipment</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Willy Derrosite</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sally Rice</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dennis Chrockrem /son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>30 Bellanca Rd Baltimore, MD 21220</b>   |                                |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | Date<br><b>May 22 1999</b>   |                                | 20c. Location - City or Town, State<br><b>Catonsville, MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Anthony C. Connelly</b>  |  |   |  | 22. Name and Address of Facility<br><b>Connolly Funeral Home of Dundalk 7110 Sollers Point Rd 21222</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Ischemic Cardiomyopathy</b><br>Due to (or as a consequence of):<br>b. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes</b><br>Due to (or as a consequence of):<br>d. |  |   |  |  |                                | Approximate Interval Between Onset and Death<br><b>36 hours</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of certifier<br><b>Kevin Brewster</b>  |  |  |                                |  |  |
|  |  | 29c. License number<br><b>191783</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 17 1999</b>  |                                |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Dr. Kevin Brewster 9000 Franklin Square Drive Baltimore Maryland 21227</b>  |  |   |  |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Klimas, Virginia





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16357

|   |  |  |  |   |   |   |   |  |  |
|---|--|--|--|---|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Sigmond Katcef</b>                             |  |  |   | 2. Date of Death<br>Month Day Year<br><b>May 20, 1999</b> |   | 3. Time of Death<br><b>0440</b>                             |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>                  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-32-2125</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.          |   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 15, 1910</b> |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>                        |   | 10c. City, Town or Location<br><b>Annapolis</b>             |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>210 S. Southwood Street</b>  |   | 10f. Zip Code<br><b>21401</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-45</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner/Operator</b>  |   | 16b. Kind of Business/Industry<br><b>Tavern/Package Goods</b>                               |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Matthew Katcef</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Zavada</b>  |   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sylvia Fiddle Katcef-Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>210 S. Southwood Street, Annapolis, MD 21401</b>  |   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Kneseth Israel Cemetery</b>   |  | Date<br><b>5/21</b>   |   | 20c. Location - City or Town, State<br><b>Annapolis, MD</b>                                 |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Thomas A. Hardisty</i>  |  |  |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>  |   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Anoxic Brain Injury</b><br>Due to (or as a consequence of):<br><b>b. Cardiac Arrest</b><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |  |  |   |   |   |   | Approximate Interval Between Onset and Death<br><b>18 days</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   |  |  |  |   |   |   |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |  |  |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospice: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>Dr. Weinstein MD</i>   |  | 29c. License number<br><b>1238445</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>May 20, 1999</b>                                  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 28e) (Type, Print)<br><b>Ira Weinstein 600 Ridgely Ave #121 Annapolis, MD 21401</b>   |  |  |  |   |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  | 32. Registrar's Signature<br><i>John B. Sparks</i>   |  |   |   |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

16358

|  |   |  |   |   |  |  |  |   |                                   |  |
|--|---|--|---|---|--|--|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Theodore Eugene Kirchner                          |  |   |   | 2. Date of Death<br>Month Day Year<br>May 19, 1999   |  | 3. Time of Death<br>0840   |   |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center |  |   |   | 4b. City, Town, or Location of Death<br>Annapolis  |  | 4c. County of Death<br>Anne Arundel  |   |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-34-1427  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>65 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Mar. 12, 1934                                 |   |                                   |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>MD  |   | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>West River  |   |                                   |  |
| Usual Residence of Decedent  |   |  |   |   |  |  |  |   |                                   |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 10e. Street and Number<br>5249 Chalk Point Road   |  | 10f. Zip Code<br>20778   |  | 10g. Citizen of What Country?<br>USA  |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1957-58   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |   |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver |  |  | 16b. Kind of Business/Industry<br>Construction                                       |   |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Clarence Eugene Kirchner  |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rachael Janette Jenkins   |  |  |   |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Rachael J. Jenkins - Mother  |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5249 Chalk Point Road, West River, MD 20778   |  |  |   |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Quaker Cemetery                                 |  | Date<br>5/22   |  | 20c. Location - City or Town, State<br>Galesville, MD   |                                   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |   |   | 22. Name and Address of Facility<br>Hardesty Funeral Home, P.A.<br>12 Ridgely Ave. Annapolis, MD 21401   |  |  |   |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Colon Cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |  |  |  |   |                                   |  |
| Approximate Interval Between Onset and Death<br>1 yr   |   |  |   |   |  |  |  |   |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |                                   |  |
|  |   |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |   |  |  |  |   |                                   |  |
| 29b. Signature and title of certifier<br>   |   |  |   |   | 29c. License number<br>D38563  |  | 29d. Date signed (Month, Day, Year)<br>May 20, 1999                                  |   |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Wayne D. Bierbaum 134 Owensville Rd West River, MD   |   |  |   |   |  |  |  |   |                                   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999   |   |  | 32. Registrar's Signature<br>   |   |  |  |  |   |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16359

|  |   |  |   |   |   |  |   |  |   |   |  |
|--|---|--|---|---|---|--|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles Kanely</b>   |  |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>18</b> Year <b>1999</b> |  | 3. Time of Death<br><b>03:50</b>                            |  |   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Baltimore Veterans Administration Medical Center</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>            |  | 4c. County of Death<br><b>Baltimore City</b>                |  |   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-38-8126</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 17, 1942</b> |  |   |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Baltimore</b>                                     |  | 10c. City, Town or Location<br><b>Middle River</b>          |  |   |   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 10e. Street and Number<br><b>114 Trailway Rd.</b>   |   | 10f. Zip Code<br><b>21220</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>0</b>  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Iron Worker</b>   |   |  |   | 16b. Kind of Business/Industry<br><b>Local 16</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles A. Kanely</b>  |   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara W. Bayer</b>   |   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gloria Baile / sister</b>   |   |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2300 Leeward Dr. Westminster, MD 21158</b>   |   |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |   |  |   | Date<br><b>5-21-99</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>Denise S. Kelly</b>  |   |  |   |   |   | 22. Name and Address of Facility<br><b>Cvach/Rosedale Funeral Home<br/>1211 Chesaco Ave. Rosedale, MD 21237</b>  |   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic lung cancer (adenocarcinoma)</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |   |   |   |  |   |  |   | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|  |   |  |   |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |   |   |  |   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   |  |   |   |   | 29c. License number<br><b>P12417</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>May 18, 1999</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jean R. Hou 22 South Greene St. Baltimore, Maryland 21201</b>   |   |  |   |   |   |  |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16360

|   |  |                                     |   |   |   |   |   |  |  |  |
|---|--|-------------------------------------|---|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CORA LINVILLE</b>                                 |                                     |   |   |   |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>14</b> Year <b>1999</b> |  | 3. Time of Death<br><b>5:15 AM</b>                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SUNRISE ASSISTED LIVING</b> |                                     |   |   |   |   | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>             |  | 4c. County of Death<br><b>HOWARD</b>                         |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>523-42-1066</b>  |                                     | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 1, 1909</b>          |  | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b> |  |
|   | Usual Residence of Decedent  |                                     |   |   |   |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George</b> |   | 10c. City, Town or Location<br><b>Laurel</b>  |   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>701 Park Avenue</b>  |  |                                     |   | 10f. Zip Code<br><b>20707</b>   |   |   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |                                     |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   |   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lonzie Denton</b>   |  |                                     |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dora Ham</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Leilani Sanders/Granddaughter</b>  |  |                                     |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>701 Park Avenue, Laurel, Maryland 20707</b> |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                     |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr.</b>   |   | Date<br><b>5/15/99</b>  |   | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>                                 |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                     |   | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road, Laurel, Maryland 20707</b>  |   |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MALNUTRITION</b><br><b>ESOPHAGEAL ACHALASIA</b><br><b>CHRONIC ATRIAL FIBRILLATION</b> |  |                                     |   |   |   |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                                     |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                     |   |   |   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                     |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |                                     |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
| 28d. Describe how injury occurred   |  |                                     |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                     |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D39629</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 14 1999</b>                                      |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ALEXANDER SY MD 10724 LITTLE PATUXENT PKWY STE 200 COLUMBIA MD 21044</b>   |  |                                     |   |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |                                     |   | 32. Registrar's Signature<br>  |   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

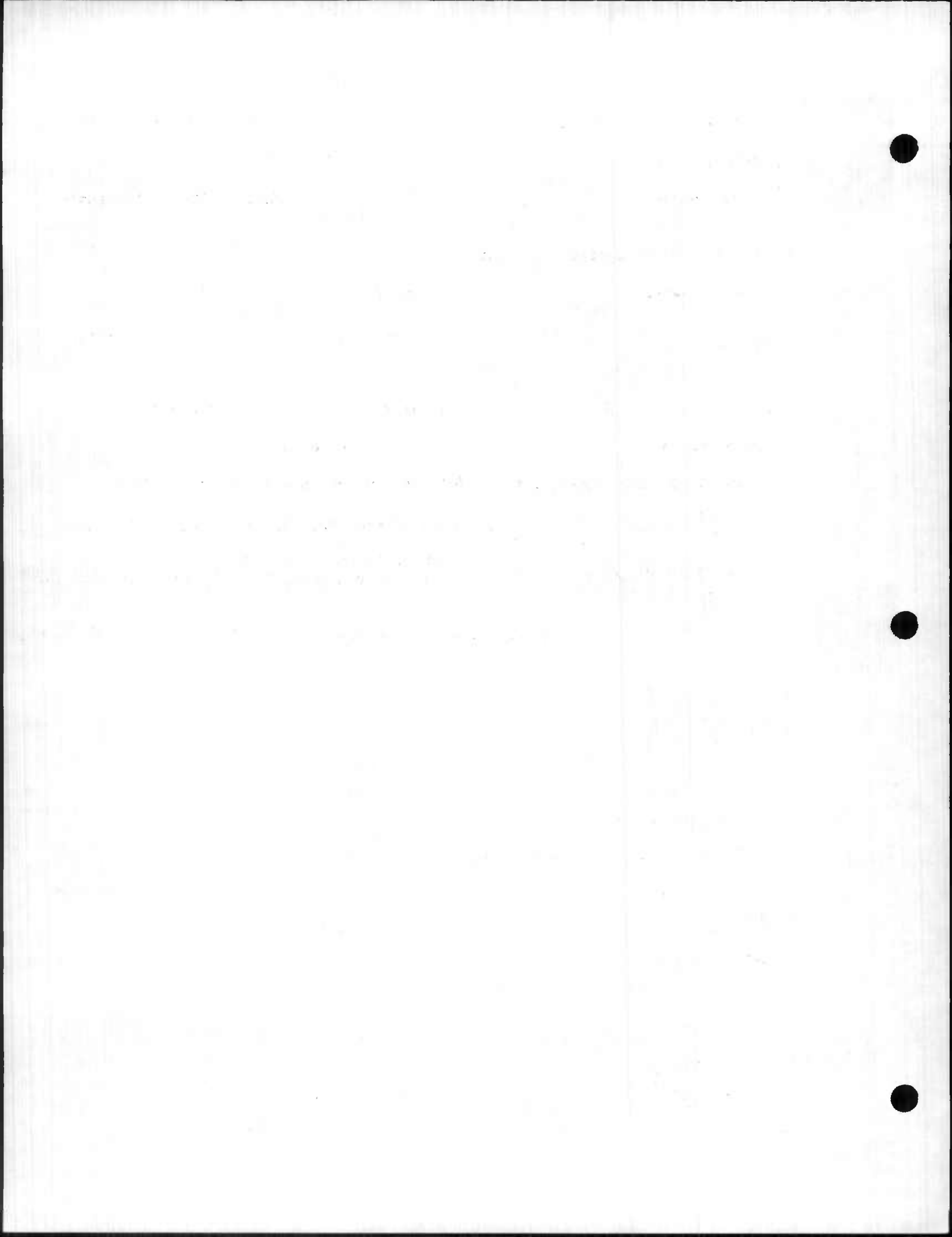
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16361

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA P. LAUCH

2. Date of Death

May 20 1999

3. Time of Death

11:50 PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

168-05-0274

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 19, 1908

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10118 Darlington Road

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

AT &amp; T

Telephone Company

17. Father's Name (First, Middle, Last)

Bengt Carlson

18. Mother's Name (First, Middle, Maiden Surname)

Sophia Borgenson

19a. Informant's Name/Relationship (Type, Print)

Carol Snyder Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10118 Darlington Road, Columbia, Maryland 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore Wash. Crematory 5/21/99 Laurel, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

5555 Twin Knolls Road, Columbia, Maryland 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

STAPHYLOCOCCAL SEPSIS

Due to (or as a consequence of):

Agotemia

Due to (or as a consequence of):

ARTEROSCLEROSIS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Days

Days

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D22856

29d. Date signed (Month, Day, Year)

May 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JERRY L. HEWITT, MD, 11055 Little Potomac Pkwy Columbia Md. 21044

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

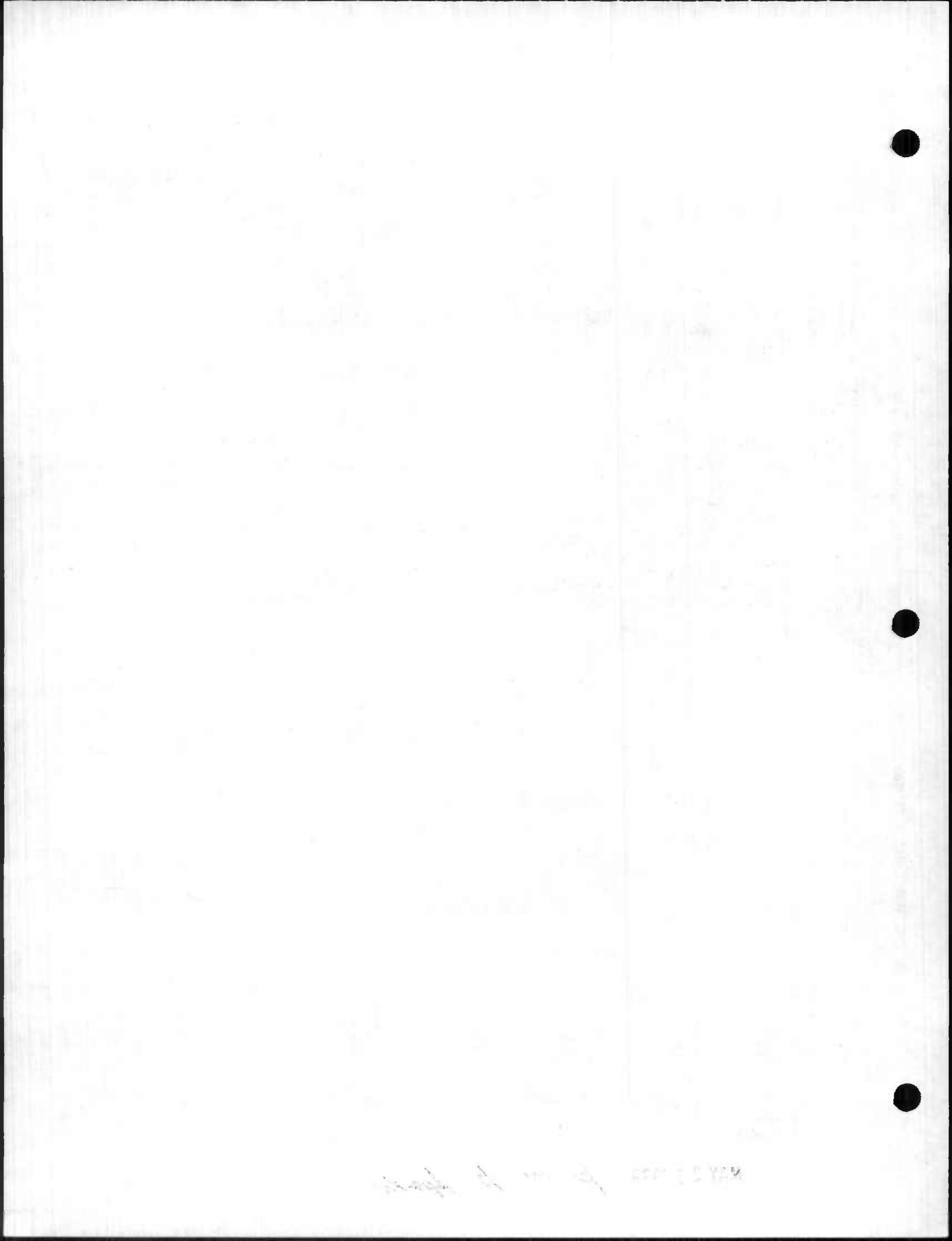
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16362

Lombardo, Naomi 5/19/99 9:20 PM

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner

Funeral Director

|  |  |   |  |   |                                |  |  |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Naomi Lombardo</b>  |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>19</b> Year <b>1999</b>   |                                | 3. Time of Death<br><b>9:20 PM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>OAKCREST CARE CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>PARKVILLE</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>219-18-8260</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>7/1/08</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  |   |                                |  |  |
| Usual Residence of Decedent  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |                                | 10c. City, Town or Location<br><b>MIDDLE RIVER</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |                                |  |  |
| 10e. Street and Number<br><b>12 BUTTERNUT DRIVE</b>  |  | 10f. Zip Code<br><b>21220</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |                                |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th GRADE</b>   |  | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY</b>   |                                | 16b. Kind of Business/Industry<br><b>FEDERAL GOVERNMENT</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>HENRY SCHOENHALS</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MATILDA TEGELER</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>WAULETTA KRUMHOLTZ DAUGHTER-IN-LAW</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 BUTTERNUT DRIVE BALTIMORE, MD 21220</b>  |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GAR.</b>   |  | Date<br><b>5/24/99</b>  |                                | 20c. Location - City or Town, State<br><b>COCKEYSVILLE, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |  |   |  |   |                                |  |  |
| Approximate interval Between Onset and Death<br><b>2 months</b>  |  |   |  |   |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>#10 breast cancer 1989</b><br><b>Advanced dementia</b>  |  |   |  |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |                                |  |  |
| 29b. Signature and title of certifier<br><b>Kendall Paulk</b>  |  |   |  | 29c. License number<br><b>D25643</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>5/20/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PAULK, KENDALL / 8800 Waithor Blvd / Baltimore MD 21234</b>   |  |   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |                                |  |  |

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM FERRELL LEDNUM

2. Date of Death

May 18, 1999

3. Time of Death

6:50 A.M.

4a. Facility Name (If not institution, give street and number)

1040 Bristol Place, First Floor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-24-6000

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

JUL 15, 1929

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

BROOKLYN PARK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1040 BRISTOL PLACE

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DELIVERY

16b. Kind of Business/Industry

ADVERTISING

17. Father's Name (First, Middle, Last)

EDGAR MILTON LEDNUM, SR

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE JEFFERSON COLLIN

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA LEDNUM, SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 461 SEVERN, MD 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN CEMETERY

Date

5/21/99

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

Sean D. Shubert

22. Name and Address of Facility

AMPOX FUNERAL HOME OF LANDBOWNE  
2719 HARMONAS FERRY RD. LANDBOWNE, MD 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

Inspection

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore H. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

May 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

Benita B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16364

|  |  |  |  |  |   |   |  |  |  |  |
|--|--|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Joseph G. Leeper   |  |  |  | 2. Date of Death<br>Month Day Year<br>May 14, 1999  |   |  |  | 3. Time of Death<br>10:48am  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>NORTH ARUNDEL HOSPITAL   |  |  |  | 4b. City, Town, or Location of Death<br>GLEN BURNIE   |   |  |  | 4c. County of Death<br>AARCOUNTY   |  |
| Funeral<br>Director                              | 5. Social Security Number<br>210-14-0767   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>74 Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br>April 13, 1925                                |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|  | Usual Residence of Decedent  |  |  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director              | 10a. State<br>Maryland   |  | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>Ferndale   |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>#7 Cromwell Ave  |  |  |  | 10f. Zip Code<br>21061  |   | 10g. Citizen of What Country?<br>U.S.  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th Grade<br>College (1-4or 5+) College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Machinist  |   |  | 16b. Kind of Business/Industry<br>Brick Refractory               |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Joseph W. Leeper  |  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary L. Toth   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>Virginia C. Leeper / Wife  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>#7 Cromwell Ave Ferndale, Maryland 21061   |   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Park  |  | 20c. Date<br>5/17/99  |   | 20d. Location - City or Town, State<br>Baltimore, Maryland                           |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Jerome Zieminski  |  |  |  | 22. Name and Address of Facility<br>George J. Gonce Funeral Home P.A.<br>4001 Ritchie Highway Baltimore, Maryland 21225   |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ACUTE MYOCARDIAL INFARCTION<br>Due to (or as a consequence of):<br>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |   |  |  |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>EMPHYSEMA<br>DIABETES.  |  |  |  |   |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner    | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |   |   |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |  |  |
| State Registrar                                  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |   |   |  |  |  |  |
|  | 29b. Signature and title of certifier<br>S. M. Leeper  |  |  |  | 29c. License number<br>D 21776  |   |  | 29d. Date signed (Month, Day, Year)<br>MAY 15 1999               |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SURA MUNDRAPO 8109 RITCHIE HWY PASADENA MD 21222   |  |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999 |  | 32. Registrar's Signature<br>B. Sparks |  |  |   |   |  |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16365

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>HANS G. MARX</b>                                 |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>17</b> Year <b>1999</b> |  | 3. Time of Death<br><b>8pm</b>             |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL</b> |   | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>          |  | 4c. County of Death<br><b>ANNE ARUNDEL</b> |
| Funeral<br>Director  | 5. Social Security Number<br><b>228-66-2271</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.                    | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.             |
|  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 11, 1945</b>                                      |   | 9. Birthplace (State or Foreign Country)<br><b>EAST GERMANY</b>     |  |  |
| Usual Residence of Decedent  |   |   |   |  |  |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>ANNE ARUNDEL</b>  |   | 10c. City, Town or Location<br><b>GLEN BURNIE</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |  |  |
| 10e. Street and Number<br><b>105 INGLEWOOD DRIVE</b>   |   | 10f. Zip Code<br><b>21060</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1965-</b><br>If Yes, Give Year or Dates: <b>1966</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GROCERY STORE MANAGER</b>   |   | 16b. Kind of Business/Industry<br><b>GROCERY</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>RICHARD G. MARX</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNELISE E. MULLER</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>KAREN I. MARX (WIFE)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>105 INGLEWOOD DRIVE, GLEN BURNIE, MD. 21060</b>   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD. VETERANS CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>5/20/99 CROWNSVILLE, MD.</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael C. Gaffian</i>   |   | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |   | Approximate Interval Between Onset and Death<br><b>30 minutes</b>   |   |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |   |  |  |
| a. <b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):  |   |   |   |  |  |
| b. <b>ATHEROSCLEROSIS</b><br>Due to (or as a consequence of):  |   |   |   |  |  |
| c.<br>Due to (or as a consequence of):   |   |   |   |  |  |
| d.<br>Due to (or as a consequence of):   |   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |
| <b>LUNG CANCER</b>   |   |   |   |  |  |
| <b>PULMONARY EMBOLUS</b>   |   |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   |  |  |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Marx</i>   |   | 29c. License number<br><b>002110</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>05/18/99</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARC A. KAPLAN, M.D. 7845 OAKWOOD Rd #300 Glen Burnie MD 21061</b>  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 17 per FH G771 5/21/99 gap

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |
|---|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas J. Malloy</b>                               |   |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>18</b> Year <b>1999</b> |  | 3. Time of Death<br><b>4:45PM</b>                                |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b> |   |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |   | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-22-3246</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                      | 8. Date of Birth (Month, Day, Year)<br><b>June 12, 1926</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b> |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Savage</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>8888 Lincoln Street, Box #374</b>  |   |   |  | 10f. Zip Code<br><b>20763</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bus Driver</b>   |   | 16b. Kind of Business/Industry<br><b>Transportation</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><del>John Malloy</del> <b>Guy Malloy</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Freda Butcher</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Etta Malloy/Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8888 Lincoln Street, Box #374, Savage, MD 20763</b>  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr.</b>   |  | Date<br><b>5/20/99</b>   |   | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>                                 |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.</b><br><b>7601 Sandy Spring Road, Laurel, Maryland 20707</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. CARDIAC ARREST</b><br>Due to (or as a consequence of):<br><b>b. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>c. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>d. Atherosclerotic Heart Disease</b> |   |   |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Hypothyroidism</b>  |   |   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28d. Describe how injury occurred  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br> <b>M.D.</b>  |   |   |  | 29c. License number<br><b>D 22549</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 19, 1999.</b>                                    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>G. M. DIN, M.D. 6510 Kenilworth Ave Riverdale M.D. 20737</b>   |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |   |   |  | 32. Registrar's Signature<br>   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16367

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|  |  |   |   |  |   |
|--|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lewis J. Mason</b>  |  | 2. Date of Death<br>Month <b>May</b> Day <b>17</b> Year <b>1999</b>   |   | 3. Time of Death<br><b>2:40AM</b>  |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>Laurel Regional Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Laurel</b>   |  | 4c. County of Death<br><b>Prince George</b> |
| 5. Social Security Number<br><b>225-14-6752</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              |
| 8. Date of Birth (Month, Day, Year)<br><b>Dec. 10, 1921</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |   |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George</b>   |   | 10c. City, Town or Location<br><b>Laurel</b>   |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |
| 10e. Street and Number<br><b>15810 Sherwood Avenue</b>   |  |   | 10f. Zip Code<br><b>20707</b>   |  | 10g. Citizen of What Country?<br><b>USA</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printer</b>   |   | 16b. Kind of Business/Industry<br><b>US Government</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Machie Mason</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kate Ingram</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lewis J. Mason, Jr/Son</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14816 Harvest Lane, Silver Spring, MD 20905</b> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Washington Cem.</b>   |   | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>  |   |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road, Laurel, Maryland 20707</b>  |   |  |   |
| 23a. Part I: Enter the condition or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Myocardial infarction</b><br><b>Renal failure</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |   |
| 29b. Signature and title of certifier<br><b>Jenny Y Moy</b>  |  | 29c. License number<br><b>D43260</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 17, 1999</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jenny Y Moy 13952 Baltimore Ave Laurel MD 20707</b>   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  | 32. Registrar's Signature<br><b>P. Sparks</b>   |   |  |   |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

16368

|   |   |   |  |   |  |  |  |
|---|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ISABELL MIKE</b>   |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MAY 18 1999</b>   |  | 3. Time of Death<br><b>0800</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Heritage Center</b>  |   |  |   | 4b. City, Town, or Location of Death<br><b>Dundalk</b>   |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>195-16-0480</b>   | 6. Sex<br><b>1 M 2 F</b>                      | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 22 1922</b> | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |
|   | Usual Residence of Decedent   |   |  |   |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>  | 10b. County<br><b>Baltimore</b>               | 10c. City, Town or Location<br><b>Essex</b>  |   |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>               |  |
|   | 10e. Street and Number<br><b>715 Dorsey Ave.</b>  |   |  | 10f. Zip Code<br><b>21221</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                |  |
|   | 11. Marital Status<br><b>1 Never Married 2 Married</b><br><b>3 Widowed 4 Divorced</b>   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b> |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>                          |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) College (1-4 or 5+)</b><br><b>12th</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembler</b>                        |   | 16b. Kind of Business/Industry<br><b>Cross &amp; Blackwell</b>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Abraham Mike</b>  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Esther Mulkey</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Colleen Felts</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2018 Oakland Road Baltimore Md. 21221</b> |  |  |  |
|   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State</b><br><b>4 Donation 5 Other (Specify)</b>   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>5/20/99 Baltimore Md.</b>  |  | Approximate Interval Between Onset and Death   |
|   | 21. Signature of Funeral Service Licensee<br><b>R. Terry Connolly</b>   |   |  | 22. Name and Address of Facility<br><b>Connolly Funeral Home of Essex</b><br><b>300 Mace Ave. Baltimore Md. 21221</b>                         |  |  |  |
|   | 23a. Per 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><b>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><b>c. DIABETES MELLITUS</b><br>Due to (or as a consequence of):<br><b>d. HYPOTHYROIDISM</b> |   |  |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>SCHIZOPHRENIA</b> |   |   |  |   |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>        | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |
| To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b> |   |  |  |  |
|   | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide</b><br><b>5 Pending investigation 6 Could not be determined</b>   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |  |
|   | 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |   |  |   |  |  |  |
| State Registrar   | 29b. Signature and title of certifier<br><b>Sariander K Tulle MD</b>  |   |  | 29c. License number<br><b>D27188</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/19/99</b>      |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sariander K Tulle 2 Mace Ave Baltimore MD 21221</b>  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |   | 32. Registrar's Signature<br><b>G. Sparks</b> |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16369

|   |   |  |   |   |  |  |  |  |
|---|---|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Bernice Q. Mangus                                 |  |   |   | 2. Date of Death<br>Month Day Year<br>May 12 1999  |  | 3. Time of Death<br>2:55 am                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center |  |   |   | 4b. City, Town, or Location of Death<br>Annapolis  |  | 4c. County of Death<br>Anne Arundel                              |  |
| Funeral<br>Director   | 5. Social Security Number<br>305-40-8494  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>92 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Aug. 13, 1906             |  |
|   | 9. Birthplace (State or Foreign Country)<br>Indiana   |  | 10a. State<br>Maryland  |   | 10b. County<br>Anne Arundel  |  | 10c. City, Town or Location<br>Crownsville                       |  |
| Usual Residence of Decedent   |   |  |   |   |  |  |  |  |
| 10a. State<br>Maryland  |   |  |   | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Crownsville   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br>1454 Fairfield Loop Road  |   |  |   | 10f. Zip Code<br>21032  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 5+   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>teacher  |  |  | 16b. Kind of Business/Industry<br>education                      |  |
| 17. Father's Name (First, Middle, Last)<br>William Henry Quinn  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ella Catherine Stevenson   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Kathy A. Walton/daughter  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>106 2nd Street, Greenwood Acres, Annapolis, MD 21401   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | 20c. Location - City or Town, State  |  |  |
| 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director   |   |  |   | 22. Name and Address of Facility<br>State Anatomy Board, 655 W. Baltimore Street<br>Baltimore, MD 21201   |  |  |  |  |
| 23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pneumonia<br>Due to (or as a consequence of):<br>b. Congestive Heart Failure<br>Due to (or as a consequence of):<br>c. CAD<br>Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|   |   |  |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|   |   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |
|   |   |  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |
|   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   | 29b. Signature and title of certifier<br>MD   |  | 29c. License number<br>D45096  |  | 29d. Date signed (Month, Day, Year)<br>5/12/99   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>M. Sheila McBride, 180 Admiral Cochrane Dr., Annapolis, MD 21401  |   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |   |  |   | 32. Registrar's Signature<br>Benita B. Sparks   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16370

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wilfred A. Nembhard

2. Date of Death

Month Day Year  
5 14 1999

3. Time of Death

3:15 p.m.

4a. Facility Name (If not Institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

081-40-7487

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12 20 1914

9. Birthplace (State or Foreign Country)

West Indies

Usual Residence of Decedent

10a. State

Md

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2503 Violet Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

2 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Minister

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Unk

18. Mother's Name (First, Middle, Maiden Surname)

Unk

19a. Informant's Name/Relationship (Type, Print)

Eudora Nembhard- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2503 Violet Avenue Baltimore, Md 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

5-22-99

20c. Location - City or Town, State

Baltimore Co, Md

21. Signature of Funeral Service Licensee

*Janette K. Jones*

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End-Stage Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Dr. Tariq Mahmood*

29c. License number

D43725

29d. Date signed (Month, Day, Year)

5/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

*B. Sparks*

State  
Registrar

May 14, 1999 3:15 p.m.  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Wilfred Nembhard  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended 19A per FH,G-771,5/21/99dhb

## Certificate of Death

Reg. No.

99 16371

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BARBARA NUSBAUM</b>                         |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>13</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>1:30 AM</b>          |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ROLAND PARK PLACE</b> |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>           |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-20-9342</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              |
|   | 8. Date of Birth (Month, Day, Year)<br><b>JUN. 21, 1918</b>                                |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |
| Usual Residence of Decedent   |  |   |  |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |   |
| 10e. Street and Number<br><b>830 WEST 40TH ST.</b>  |  |   | 10f. Zip Code<br><b>21211</b>  |  | 10g. Citizen of What Country?<br><b>USA</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |   |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN GOLDBERG</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT RICHARD NUSBAUM / SON</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9505 MEADOWS FARM DR. OWINGS MILLS, MD 21117</b> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OHEB SHALOM MEMORIAL PARK</b>  |  | 20c. Location - City or Town, State<br><b>5/14/99 REISTERSTOWN, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>Scott M. Cutler</i>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Acute Renal Failure</b>   |  |   |  |  |   |
| Due to (or as a consequence of):<br><b>DM</b>   |  |   |  |  |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |   |
| Due to (or as a consequence of):  |  |   |  |  |   |
| Due to (or as a consequence of):  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>5/13/99</b>  |  | 28b. Time of Injury<br><b>11:00</b> M  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |   |
| 29b. Signature and title of certifier<br><i>Gregory P. Walker</i>   |  | 29c. License number<br><b>D25662</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/13/99</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GREGORY WALKER, MD 3838 ROLAND AVE. BALTIMORE, MD</b>  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 20 1999</b>   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16372

|   |   |   |  |   |   |  |   |  |
|---|---|---|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ronald Wayne Olinger</b>                                 |   |  |   | 2. Date of Death<br>Month <b>MAY</b> 13, 1999 Year      |  | 3. Time of Death<br><b>1327 PM</b>                            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b> |  | 4c. County of Death<br><b>HOWARD</b>                          |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>545-60-2634</b>   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.        |  | 8. Date of Birth (Month, Day, Year)<br><b>August 25, 1944</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Oklahoma</b>   |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Howard</b>                            |  | 10c. City, Town or Location<br><b>Marriottsville</b>          |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>1925 Marriottsville Road</b>   |   | 10f. Zip Code<br><b>21104</b>  |   |  |
| 10g. Citizen of What Country?<br><b>U.S.</b>  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1965-1968</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed - Contracting</b>   |   | 16b. Kind of Business/Industry<br><b>General Contracting</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William A. Olinger</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Foreman</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Phyllis A. Olinger / Wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1925 Marriottsville Road, Marriottsville, Maryland 21104</b>                                 |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland State Veterans Cem.</b>   |  | Date<br><b>5/18/99</b>  |   | 20c. Location - City or Town, State<br><b>Crownsville, Maryland</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Donna M. Zmamirowski</i>  |   | 22. Name and Address of Facility<br><b>George J. Gonce Funeral Home P.A.</b><br><b>4001 Ritchie Highway Baltimore, Maryland 21225</b>   |  | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Fatty Liver</b><br>Due to (or as a consequence of):<br><b>Chronic Alcoholism</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>e. _____<br>Due to (or as a consequence of):<br>f. _____<br>Due to (or as a consequence of):<br>g. _____<br>Due to (or as a consequence of):<br>h. _____ |   | Approximate Interval Between Onset and Death   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>M</b>   |   |  |
| 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Sam Cohen MD</i>  |   | 29c. License number<br><b>O.C.M.E.</b>   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>MAY 14, 1999</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1741 T. ALON WICKES MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |   | 32. Registrar's Signature<br><i>Shirley B. Sparks</i>  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16373

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard

2. Date of Death

Month  
MayDay  
20Year  
1999

3. Time of Death

0902

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

216-42-1013

6. Sex

M 2 F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept 3, 1943

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

534 Brighton Place

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No  
Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Diesel Mechanic

16b. Kind of Business/Industry

Trucking Company

17. Father's Name (First, Middle, Last)

Joseph M. Polanka

18. Mother's Name (First, Middle, Maiden Sumame)

Mildred Chaney

19a. Informant's Name/Relationship (Type, Print)

Cynthia L. Polanka (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

534 Brighton Place, Baltimore, Maryland 21221

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Mem. Gardens

Date

5/24/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

John W. Burkowski

22. Name and Address of Facility

Bruzdzinski Funeral Home, P.A.  
1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

20 min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

28. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

MD

29c. License number

RES-006

29d. Date signed (Month, Day, Year)

MAY 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Faulkner

600 North Wolfe St Baltimore, MD 21287-9106

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Spaw

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Charles J. Parsons, Jr.</b>                 |   |  |  | 2. Date of Death<br>Month Day Year<br><b>May 17, 1999</b> |  | 3. Time of Death<br><b>6:27 a.m.</b>                       |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>12413 Radnor Lane</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>     |  | 4c. County of Death<br><b>Prince George</b>                |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>155-30-6385</b>  |   | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br><b>July 5, 1915</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                |   | 10a. State<br><b>MD</b>                          |  | 10b. County<br><b>Prince George</b>                       |  | 10c. City, Town or Location<br><b>Laurel</b>               |   |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>12413 Radnor Lane</b>   |   | 10f. Zip Code<br><b>20708</b>  |  | 10g. Citizen of What Country?<br><b>USA</b> |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>6</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Colonel</b>   |  | 16b. Kind of Business/Industry<br><b>US Army</b>   |   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles J. Parsons, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mabel E. Plimpton</b>  |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen D. Parsons/Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12413 Radnor Lane, Laurel, Maryland 20708</b>  |   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore Washington Cr.</b>   |  | Date<br><b>5/21/99</b>   |   | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Fleck Funeral Home, Inc.</b><br><b>7601 Sandy Spring Road, Laurel, Maryland 20707</b>   |   |  |  |   |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Progressive Multiple Myeloma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>21 Mos.</b>   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D23743</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/20/99</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (item 23e) (Type, Print)<br><b>Martin Weltz, MD 7525 GRgreenway Ct. DR., Greenbelt, MD 20770</b>  |  |   |  |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

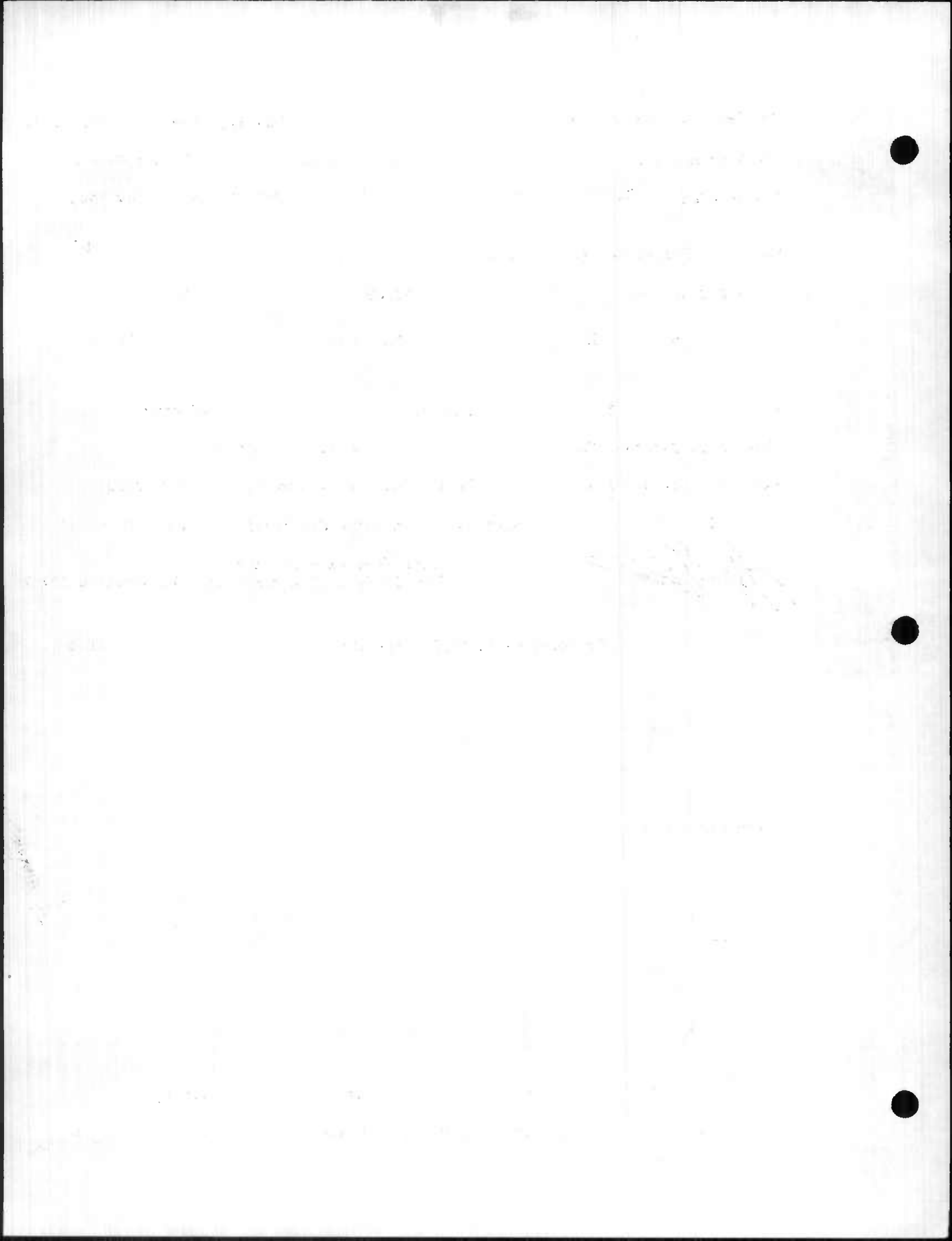
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





99 16375

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth Elizabeth Prato</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>5</b> DAY <b>18</b> YEAR <b>1999</b>   |  | 3. TIME OF DEATH<br><b>1035A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-01-8437</b>   |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4-29-1916</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ManorCare Bossville</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, MD</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>2628 E. Joppa Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>10</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alfred Floyd Childs</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Grace Agnes Chapman</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary McCoy (Daughter)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2628 E. Joppa Road, Baltimore, MD 21234</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>5/21/99 Woodlawn, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Paula L Lemmes</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Witzke Funeral Homes, Inc.<br/>1630 Edmondson Avenue, Catonsville, MD 21228</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration pneumonia</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Aspiration pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>Dehydration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <b>malnutrition</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>Approximate interval Between Onset and Death<br><b>10-12 day</b><br><b>2 week</b><br><b>months</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia - Noninsulin dependent Diabetes Mellitus</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>F. 1699 M-D</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D48271</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>5-19-99</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FAHEE Koulimo 7600 Osler Drive, Suite 203, Towson, MD, 21204</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>B. Sparks</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 16376

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Frances Paul

2. Date of Death

Month  
MayDay  
19Year  
1999

3. Time of Death

2:05 P.M.

4a. Facility Name (If not institution, give street and number)

Chesapeake Hopice House

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

219 20 9246

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hour

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 1, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5308 - 4th Street

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14-or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Baker

16b. Kind of Business/Industry

Bakery

17. Father's Name (First, Middle, Last)

Joseph Kadan

18. Mother's Name (First, Middle, Maiden Surname)

Marie Baburek

19a. Informant's Name/Relationship (Type, Print)

Patricia M. Konopik / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Carolina Drive

Frankford, Delaware 19945

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Memorial Park

Date

5/21/99

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Jerome Zramkowski

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Breast cancer  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

L. Seenivasan MD

29c. License number

D 17743

29d. Date signed (Month, Day, Year)

5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. SEENIVASAN, MD, 606 HAMMONDS LV, BALTIMORE, MD, 21225

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16377

|   |  |                                 |   |  |  |  |   |   |
|---|--|---------------------------------|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT RUTLEDGE</b>   |                                 |   |  | 2. Date of Death<br>Month Day Year<br><b>MAY 19 1999</b>   |  | 3. Time of Death<br><b>1825 Hrs.</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL</b>  |                                 |   |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>   |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-05-9281</b>  |                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>09-22-04</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>SC</b> |
|   | Usual Residence of Decedent  |                                 |   |  |  |  |   |   |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  | 10b. County<br><b>BALTIMORE</b> | 10c. City, Town or Location   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |
|   | 10e. Street and Number<br><b>2 WALDEN WILLOW COURT</b>   |                                 |   | 10f. Zip Code<br><b>21207</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 TH GRADE</b>   |                                 | College (1-4or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ROOFER</b>   |  | 16b. Kind of Business/Industry<br><b>HOME IMPROVEMENT</b>                                   |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>GEORGE RUTLEDGE</b>  |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIRGINIA SQUIRE</b>  |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>AMELIA RUTLEDGE   DAUGHTER</b>  |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 WALDEN WILLOW CT., BALTO. MD. 21207</b>  |  |   |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST</b>  |  | Date<br><b>5-27-99</b>   |  | 20c. Location - City or Town, State<br><b>OWINGS MILLS, MD</b>                              |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Vaughn C. Greene</b>   |                                 |   |  | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE<br/>5151 BALTO. NAT'L PIKE, BALTO. MD. 21229</b>   |  |   |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MULTI LOBAR PNEUMONIA</b>  |                                 |   |  |  |  | Approximate Interval Between Onset and Death<br><b>1 DAY</b>                                |   |
|   | Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):  |                                 |   |  |  |  |   |   |
|   | Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |                                 |   |  |  |  |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPOTHYROIDISM, DEMENTIA</b>  |                                 |   |  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                 | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |                                 | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   |  |                                 | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |   |   |
|   |  |                                 |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| State Registrar                               | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 |   |  |  |  |   |   |
|   | 29b. Signature and title of certifier<br><b>C. Ravi Mo</b>   |                                 |   |  | 29c. License number<br><b>D37333</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 19 1999</b>                                   |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>C. RAVI MO, NHC, BALTO. MD 21133</b>  |                                 |   |  |  |  |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |                                 | 32. Registrar's Signature<br><b>P. Sparks</b>   |  |  |  |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



99-2849-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

WILLIAM

State of Maryland / Department of Health and Mental Hygiene

RAY ITEMS: #23 PART I, 27, 28A-F PER MEO G772 6-16-99 **Certificate of Death**

Reg. No.

99 16378

|  |  |                          |   |  |  |  |  |   |   |  |
|--|--|--------------------------|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William Ray, Jr.</b>                        |                          |   |  |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>17</b> Year <b>1999</b>  |   | 3. Time of Death<br><b>7:35P.M.</b>                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2309 HARFORD ROAD</b> |                          |   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>NA</b>                      |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-58-6161</b>  |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>10-08-51</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|  | Usual Residence of Decedent  |                          |   |  |  |  |  |   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 10e. Street and Number<br><b>2309 Harford Road</b>   |  |                          |   |  |  | 10f. Zip Code<br><b>21218</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b><br>College (14 or 5+) <b>NA</b>  |  |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unemployed</b> |  |  |  | 16b. Kind of Business/Industry<br><b>NA</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Ray</b>  |  |                          |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Esther Dunlap</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Hughes</b>   |  |                          |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21206 4909 Gunther Avenue Apt. "B" #4 Baltimore, MD</b> |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshell Mem. Gardens</b>   |  |  | Date<br><b>05-24-99</b>  |  | 20c. Location - City or Town, State<br><b>Dundalk, MD</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                          |   |  |  | 22. Name and Address of Facility <b>Baltimore, Maryland @1202 WM.C.March FH 1101 E. North Avenue</b>   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>ISOPROPANOL INTOXICATION</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                          |   |  |  |  |  |   |   | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                          |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|  |  |                          |   |  |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|  |  |                          |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined   |  |                          | 28a. Date of Injury (Month, Day, Year)<br><b>Found: 5-17-99</b>   |  | 28b. Time of Injury<br><b>Found: 7:00 P</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                          |   | 28d. Describe how injury occurred<br><b>UNKNOWN</b>   |  |
|  |  |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE</b>  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2309 HARFORD ROAD BALTIMORE, MD.</b> |   |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                          |   |  |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br>   |  |                          |   |  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 17, 1999</b>  |   |  |
| 30. Name and address of person who completed cause of death item 23a) (Type, Print)<br><b>THEODORE M. K... 111 Penn Street, Baltimore, Maryland 21201</b>  |  |                          |   |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |                          | 32. Registrar's Signature<br>   |  |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Handwritten signature

OPPT F. S. YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16379

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stewart Edward Russell

2. Date of Death

May 18, 1999

3. Time of Death

6:30 p.m.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

234-26-1799

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 3, 1919

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 Helena Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Steel Mill

17. Father's Name (First, Middle, Last)

Roland Russell

18. Mother's Name (First, Middle, Maiden Surname)

Verna Board

19a. Informant's Name/Relationship (Type, Print)

Russell E. Slocum (stepson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Helena Avenue, Baltimore, Maryland 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

5/21/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Bruzdinski Funeral Home, P.A.

1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Coronary artery disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic obstructive lung disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident

3 ☐ Suicide 4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

041614

29d. Date signed (Month, Day, Year)

May 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Alan Hille MD 4920 Campbell Blvd White Marsh, MD*

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16380

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA ROLLINS

2. Date of Death

MAY 16 1999

3. Time of Death

1045 PM

4a. Facility Name (If not institution, give street and number)

Golden Oaks Nursing Home

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

Funeral  
Director

5. Social Security Number

164-22-3317

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

8. Date of Birth (Month, Day, Year)

Feb. 29, 1928

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9000 Briarcroft Lane #130

10f. Zip Code

20708

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry Brann

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Madden

19a. Informant's Name/Relationship (Type, Print)

William Rollins/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9000 Briarcroft Lane, Laurel, Maryland 20708

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Washington Cr. 5/19/99 Laurel, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SUSPECTED SEPSIS  
Due to (or as a consequence of):

1 DAY

b. PNEUMONIA  
Due to (or as a consequence of):

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. ORGANIC BRAIN SYNDROME  
Due to (or as a consequence of):

TODAYS

d. CEREbroVASCULAR DISEASE  
Due to (or as a consequence of):

TODAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bipolar Disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

025422

MAY 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13952 BOUTWORTH AVE.  
LAUREL, MD 20707

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Spaw

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16381

|  |  |  |  |   |   |  |   |  |
|--|--|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Michael John Reddy   |  |  |   |   | 2. Date of Death<br>Month Day Year<br>MAY 18, 1999   |   | 3. Time of Death<br>1234 AM                          |
|  | 4a. Facility Name (If not institution, give street and number)<br>BAYVIEW MEDICAL CENTER   |  |  |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |   | 4c. County of Death<br>N/A                           |
| Funeral<br>Director                              | 5. Social Security Number<br>219-52-2580   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>52 Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Sept. 2, 1946   |   | 9. Birthplace (State or Foreign Country)<br>Maryland |
|  | Usual Residence of Decedent  |  |  |   |   |  |   |  |
| To Be Completed by Funeral Director              | 10a. State<br>Maryland   | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Dundalk   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br>203 German Hill Road   |  |  | 10f. Zip Code<br>21222  |   | 10g. Citizen of What Country?<br>United States   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                            |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Years<br>College (14 or 5+) Collage  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Production Scheduling   |   |   | 16b. Kind of Business/Industry<br>Steel Industry   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Leo Reddy  |  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elton P. Hitchens                         |   |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Linda F. Reddy/Wife   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>203 German Hill Road Dundalk, Maryland 21222 |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holly Hill Mem. Gdns.  |   | Date<br>5/20/99   |  | 20c. Location - City or Town, State<br>Middle River, MD                                     |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222                         |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>Arteriosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>MUSCULAR DYSTROPHY</u> |  |  |   |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |   |   |  |   |  |
| To Be Completed by Physician/Medical Examiner    | 24a. Was an autopsy performed?<br>INSPECTION<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |   |  |
| State Registrar                                  | 29b. Signature and title of certifier<br>  |  |  | 29c. License number<br>O.C.M.E.   |   | 29d. Date signed (Month, Day, Year)<br>MAY 18, 1999  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201   |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999 |  | 32. Registrar's Signature<br>  |  |   |   |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16382

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph C. Rondo

2. Date of Death

Month  
MAYDay  
19Year  
1999

3. Time of Death

8:26 A.M.

4a. Facility Name (If not Institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-64-7742

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08/06/1953

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6840 Leslie Road

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

if Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Marine Supplies

17. Father's Name (First, Middle, Last)

Charles J. Rondo

18. Mother's Name (First, Middle, Maiden Surname)

Mary K. Bognanni

19a. Informant's Name/Relationship (Type, Print)

Debi Rondo/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4110 Erdman Avenue Baltimore, Maryland 21213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greenmount Crematory

Date

5/24/99

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

David J. Weber Funeral Homes, P.A.  
401 S. Chester St. Baltimore, Maryland 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

1 MONTH

Due to (or as a consequence of):

b. METASTATIC TONGUE CANCER

6 MONTH'S

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Fred Chan

29c. License number

D53436

29d. Date signed (Month, Day, Year)

MAY 19 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRED CHAN 6761 NORTH CHARLES STREET BALTIMORE MARYLAND 21204

31. Date filed (Month, Day, Year)

MAY 21 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Robert Respass  
2. Date of Death 5/20/1999  
3. Time of Death 1:45 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) 1509 Idelwilde Road  
4b. City, Town, or Location of Death Catonsville  
4c. County of Death Baltimore

5. Social Security Number 215-18-0902  
6. Sex 1 ☒ M 2 ☐ F  
7. Age (In yrs. last birthday) 80  
8. Date of Birth 11/11/1918  
9. Birthplace (State or Foreign Country) Tenn

Usual Residence of Decedent  
10a. State Md  
10b. County Baltimore  
10c. City, Town or Location Catonsville  
10d. Inside City Limits ☒ Yes 2 ☐ No

10e. Street and Number 1509 Idelwilde Road  
10f. Zip Code 21228  
10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 ☐ Yes 2 ☒ No  
14. Race - American Indian, Black, White, etc. Specify white

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 6  
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant  
16b. Kind of Business/Industry BG&E

17. Father's Name (First, Middle, Last) Homer M. Respass  
18. Mother's Name (First, Middle, Maiden Surname) Margaret Cox

19a. Informant's Name/Relationship (Type, Print) Carolyn Respass/wife  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Idelwilde Road, Catonsville, Md. 21228

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) Maple Wood Cemetery  
20c. Location - City or Town, State Elkins, W. Va

21. Signature of Funeral Service Licensee M. K. Marshall  
22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc  
736 Edmondson Avenue, Balto., Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. GASTRIC CANCER  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown  
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☒ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29b. Signature and title of certifier  
29c. License number MD D29373  
29d. Date signed (Month, Day, Year) 5/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC J. SEIFTER, MD 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

31. Date filed (Month, Day, Year) MAY 21 1999  
32. Registrar's Signature B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Robert Respass

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20+1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16384

|  |  |  |   |   |  |  |   |   |   |  |
|--|--|--|---|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Agatha Smith</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>May 17, 1999</b>  |  |   |   | 3. Time of Death<br><b>0116</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |   | 4c. County of Death   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-74-5140</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>12-25-1935</b>                |   | 9. Birthplace (State or Foreign Country)<br><b>West Indies</b>  |  |
|  | Usual Residence of Decedent  |  |   |   | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>NA</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   | 10e. Street and Number<br><b>5302 Gist Avenue</b>  |  | 10f. Zip Code<br><b>21215</b>   |   | 10g. Citizen of What Country?<br><b>U S A</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th grade</b><br>College (1-4 or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Day Care Provider</b>             |   |  |  | 16b. Kind of Business/Industry <b>Unk</b>                               |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Eugene Robinson</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eva Compass</b>  |  |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Wren Smith - Husband</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5302 Gist Avenue Baltimore, Md 21215</b>   |  |   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |   | Data<br><b>5-22-99</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore Co, Md</b>          |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Synette K. Jones</i>   |  |   |   | 22. Name and Address of Facility<br><b>March F/H West<br/>4300 Wabash Avenue Baltimore, Md 21215</b>   |  |   |   |   |  |
|  | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Tracheal Obstruction</b><br>Due to (or as a consequence of):<br><b>b. Metastatic Tumor Compressing the Trachea</b><br>Due to (or as a consequence of):<br><b>c. Primary Breast Cancer</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |  |  |   |   | Approximate Interval Between Onset and Death<br><b>1 hour</b><br><b>1 year</b><br><b>20 years</b>                                       |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |  |   |   |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)                           |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred                     |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Joseph D. Spauls</i> |   |   |  | 29c. License number<br><b>00023981</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/18/99</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>2401 West Belvedere Av. Baltimore, Md.</b>  |  |  |   |   |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |  |   |   |  |  |   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16385

Certificate of Death

AMENDED #26 & 20b PER FH & MD G771 5/21/99 AF

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|--|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Clarence Edward Shiflett</b>  |  |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 15, 1999</b>  |   | 3. Time of Death<br><b>4:55 A.M.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice at Mercy Med Ctr</b>   |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>235-18-7140</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 8, 1921</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |  |
| Usual Residence of Decedent  |  |  |  |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>123 E. Gittings Street</b>  |  |  |  | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A</b>  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd Grade</b><br>College (1-4 or 5+) <b>N/A</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Rigger</b>   |  |  | 16b. Kind of Business/Industry<br><b>Self Employed</b>                  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Mack Shiflett</b>  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Mary Martha McCue</b>  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kimberly Manalansan Granddaughter</b>   |  |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>123 E. Gittings St. Balto MD 21230</b> |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakeview Mem Park</b>   |  | Date<br><b>5/17/99</b>   |  | 20c. Location - City or Town, State<br><b>Sykesville Maryland</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Christina L. Hittor</i>  |  |  |  | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Homes, P.A.<br/>130 E Fort Ave. Balto MD 21230</b>   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <i>Congestive Heart Failure</i><br>Due to (or as a consequence of):<br><br>b. <i>Coronary Artery Disease</i><br>Due to (or as a consequence of):<br><br>c. <i>Hypertension</i><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><br><i>Abriel P. Brillerton</i><br><i>Hyper Lipidemia</i><br><i>Chronic Renal Insufficiency</i> |  |  |  |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of causa of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Hospice <input type="checkbox"/> Other (Specify) <b>Stella Maris at Mercy</b> |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Christina L. Hittor</i>  |  |  |  | 29c. License number<br><b>05J283</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>5/17/99</b>                   |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Christina L. Hittor 1477 South Hancock St Baltimore MD 21230</b>  |  |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |  |  | 32. Registrar's Signature<br><i>James B. Sparks</i>  |  |  |   |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



PERI 13 YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16386

Amend Item # 7, per FH, G771 5/21/99 gap

## Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |   |  |
|--|---|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Andrew C. Stewart</b>  |  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>16</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>5:30 PM</b>                                      |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Chesapeake Future Care</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Arnold</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-07-0827</b>   | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>09/09/1917</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |
|  | Usual Residence of Decedent   |  |  |   |   |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Anne Arundel</b>   | 10c. City, Town or Location<br><b>Annapolis</b>  |   |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |   |  |
|  | 10e. Street and Number<br><b>1313 Old Pine Court</b>  |  |  | 10f. Zip Code<br><b>21401</b>                         |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
|  | 11. Marital Status<br><b>1 Navar Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates: <b>WWII</b>                        |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify:            |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8th</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Crane Operator</b> |   | 16b. Kind of Business/Industry<br><b>Western Electric</b>   |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8th</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Crane Operator</b> |   | 16b. Kind of Business/Industry<br><b>Western Electric</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>Charles Stewart</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lena Schmitt</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Marie Stewart/Wife</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1313 Old Pine Court Annapolis, Maryland 21401</b> |  |   |  |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>                              |   | 20c. Location - City or Town, State<br><b>5/18/99 Baltimore, Maryland</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Kathleen Weber CFSP</b>   |  | 22. Name and Address of Facility<br><b>David J. Weber Funeral Homes, P.A.<br/>401 S. Chester Street Baltimore, Maryland 21231</b>  |   |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. upper gastrointestinal hemorrhage days<br>Due to (or as a consequence of):<br>b. infected left groin graft site weeks<br>Due to (or as a consequence of):<br>c. ischemic right lower extremity weeks<br>Due to (or as a consequence of):<br>d. peripheral vascular disease years |  |  |   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>right below knee amputation,<br/>left heel decubitus ulcer, sacral<br/>decubitus ulcer, poor nutritional status</b> |   |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |   |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b> |  |   |   |  |   |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>                       |   | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred  |  |   |   |  |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred  |  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><b>2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |   |  |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>  |   | 29c. License number<br><b>D41955</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5-17-99</b> |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rebecca Elton MD 1454 B &amp; A Blvd Arnold MD 21012</b>  |   |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16387

|   |   |  |   |   |  |  |   |  |
|---|---|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dolly Fay Smith</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>May 15, 1999</b>  |  | 3. Time of Death<br><b>5:30 AM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>18 Decatur Road</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Middle River</b>  |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>414-34-7938</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>March 16, 1924</b>                                   |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Middle River</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>18 Decatur Road</b>  |  |   | 10f. Zip Code<br><b>21220</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 Years</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Factory Worker</b>                |   |  | 16b. Kind of Business/Industry<br><b>Factory</b>   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Haskew Bowen</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Molly Reynolds</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Linda Schmidt</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18 Decatur Road Middle River, Maryland 21220</b>  |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |   | Date<br><b>5/19/1999</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>   |  |  |   |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>BREAST CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |   |  |  |   | Approximate Interval Between Onset and Death<br><b>4</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)                                     |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>                                  |   | 29c. License number<br><b>D29071</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5.18.99</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KAVI ANANDA KRISHNAN 24 N. EUTAW ST #305 BALTIMORE MD 21201</b>  |   |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |   | 32. Registrar's Signature<br>  |   |   |  |  |   |  |



## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |   |                                      |  |
|--|---|---|--|--|--|--|---|--------------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>GARY WAYNE STREET                       |   |  |  | 2. Date of Death<br>Month: MAY Day: 20 Year: 1999    |  | 3. Time of Death<br>0056                            |                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>3808 BAYVILLE RD. |   |  |  | 4b. City, Town, or Location of Death<br>Middle River |  | 4c. County of Death<br>BALTIMORE                    |                                      |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-46-8775  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>50 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 16 1948 |                                      |  |
|  | 9. Birthplace (State or Foreign Country)<br>Tennessee                               |   | 10a. State<br>Md.  |  | 10b. County<br>Baltimore                             |  | 10c. City, Town or Location<br>Middle River         |                                      |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>3808 Bayville Road   |  | 10f. Zip Code<br>21220   |   | 10g. Citizen of What Country?<br>USA |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12th<br>College (1-4 or 5+):   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Steel Worker   |  | 16b. Kind of Business/Industry<br>Eastern Stainless  |  |  |   |                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Hubert Street   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Pearl Neal  |  |  |   |                                      |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>David Street / son   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6506 Ridge Road Baltimore Md. 21237   |  |  |   |                                      |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bennett Cemetery  |  | Date<br>5/25/99  |  | 20c. Location - City or Town, State<br>Bakerville NC   |   |                                      |  |
| 21. Signature of Funeral Service Licensee<br>R. Terry Connolly   |   |   |  | 22. Name and Address of Facility<br>Connelly Funeral Home of Essex<br>300 Mace Ave. Baltimore Md. 21221  |  |  |   |                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   | a. Contact gunshot wound of head<br>Due to (or as a consequence of):  |  | b. Due to (or as a consequence of):  |  | c. Due to (or as a consequence of):  |   | d. Due to (or as a consequence of):  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>Limited<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br>5-20-99  |   | 28b. Time of Injury<br>0020 M        |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred<br>Subject shot self  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Residence  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>3808 Bayville Road<br>Baltimore County, Maryland                       |   |                                      |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                      |   | 29b. Signature and title of certifier<br>Stephen S. Radentz, M.D.   |  | 29c. License number<br>O.C.M.E   |  | 29d. Date signed (Month, Day, Year)<br>MAY 20, 1999  |   |                                      |  |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br>Stephen S. Radentz   |   | 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |  | 32. Registrar's Signature<br>B. Sparks   |  | 33. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br>111 Penn Street, Baltimore, Maryland 21201                     |   |                                      |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16389

|   |  |  |   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>John Franklin Sockriter, Sr.   |  |   |  |  | 2. Date of Death<br>Month Day Year<br>May 18, 1999  |  | 3. Time of Death<br>8:44 A.M.  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Harbor Hospital Center   |  |   |  |  | 4b. City, Town, or Location of Death<br>Baltimore   |  | 4c. County of Death<br>N/A   |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>219-30-2202   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>64 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>Jan 28, 1935                                  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|   | Usual Residence of Decedent  |  |   |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland   |  | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore   |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br>3710 Ninth Street  |  |   |  | 10f. Zip Code<br>21225   |   | 10g. Citizen of What Country?<br>USA   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korea |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3 College (14 or 5+) 0  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver  |   |  | 16b. Kind of Business/Industry<br>News American Publishing Co.                                     |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Peter T. Sockriter  |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Daisy E. Wilkens   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19e. Informant's Name/Relationship (Type, Print)<br>John Franklin Sockriter, Jr. SON   |  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>226 Cheddington Rd., Linthicum, Md. 21090  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Pk.   |  |  | Date<br>May 21, 1999  |  | 20c. Location - City or Town, State<br>Glen Burnie, Md.  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>McCully-Polyniak Funeral Home, P.A.<br>237 E. Patapsco Ave., Balto., Md. 21225-1856                                     |  |  |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>s. CARDIOMEGALY<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   |  |  |  |  |
| State<br>Registrar                            | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                    |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>O.C.M.E.  |   | 29d. Date signed (Month, Day, Year)<br>May 19, 1999                                  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Maryland Sockriter 111 Penn Street, Baltimore, Maryland 21201  |  |   |  |  |   |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>MAY 21 1999   |  | 32. Registrar's Signature<br>   |  |  |   |  |  |  |  |

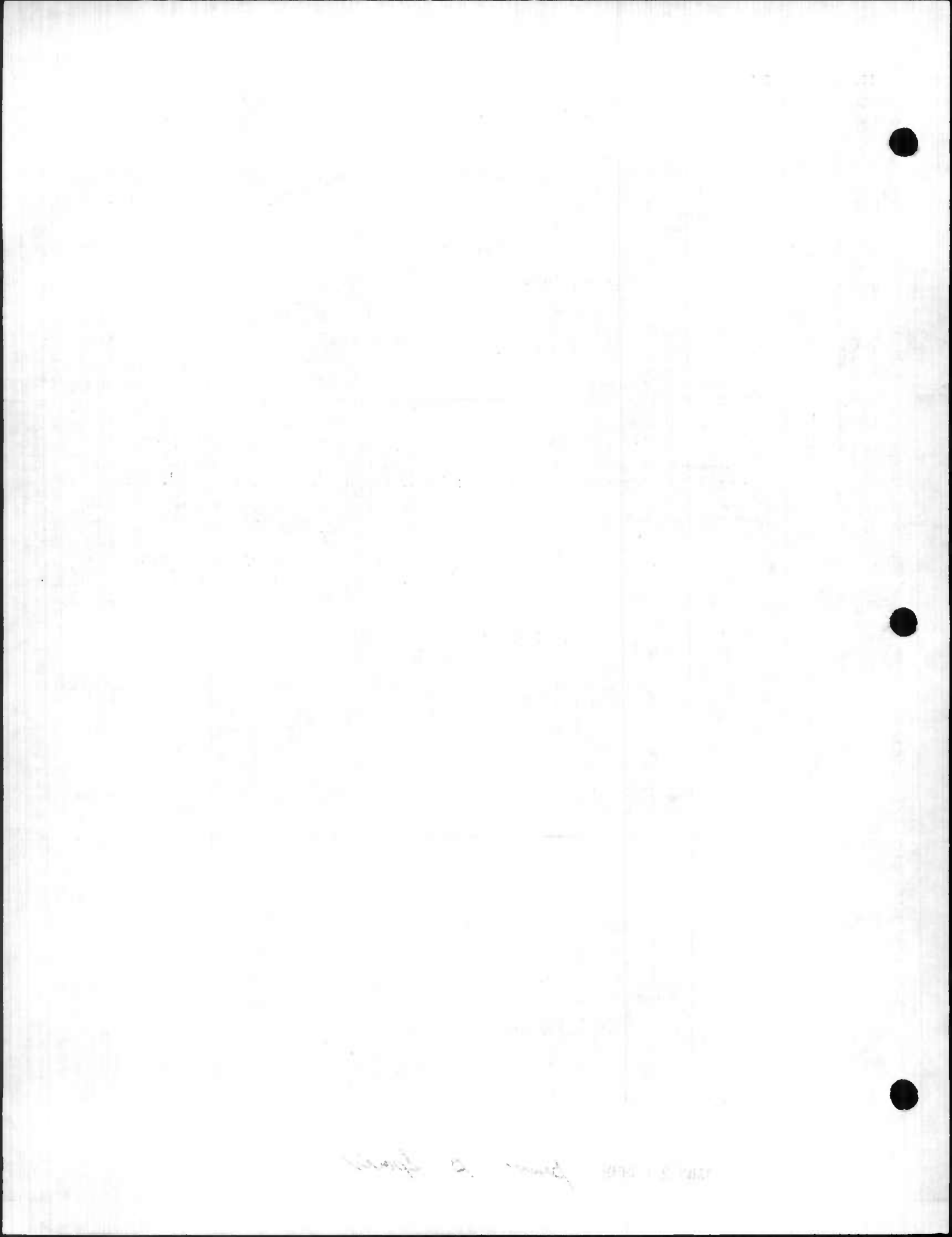
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16390

## Certificate of Death

Reg. No.

|   |   |  |  |   |   |  |   |  |
|---|---|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ADAM A. STALMANN SR.</b>                         |  |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>18</b> Year <b>1999</b> |  | 3. Time of Death<br><b>10:07 AM</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>            |  | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217 16 5945</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 14, 1924</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                     |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>3704 St. Margaret Street</b>  |  | 10f. Zip Code<br><b>21225</b>   |   | 10g. Citizen of What Country?<br><b>U.S.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>W.W. II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Inspector</b>                                    |  | 16b. Kind of Business/Industry<br><b>Westinghouse</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>John Stalman</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Raska</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Ward / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>342 Monticello Court Glen Burnie, Maryland 21061</b>  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><i>Donna M. Brancuski</i>  |   | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. SEPSIS</b><br>Due to (or as a consequence of):<br><b>b. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>37 DAYS</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   |  |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Sameer B. Badi</i> <b>MEDICAL RESIDENT PHYSICIAN P13140</b>  |   |  |
| 29c. License number<br><b>P13140</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>MAY 18, 1999</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAMEER BADI MD 3001 S HANOVER STREET, BALTIMORE, MD</b>  |   | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |  |
| 32. Registrar's Signature<br><i>B. Badi</i>   |   | 32. Registrar's Signature<br><i>B. Badi</i>  |  | 32. Registrar's Signature<br><i>B. Badi</i>   |   | 32. Registrar's Signature<br><i>B. Badi</i>  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

1. The first part of the report is devoted to a general description of the project and its objectives. It also includes a brief review of the literature on the subject.

2. The second part of the report describes the methodology used in the study. This includes a detailed description of the experimental design, the subjects, and the data collection procedures.

3. The third part of the report presents the results of the study. This includes a description of the data, the statistical analysis, and the conclusions drawn from the results.

4. The fourth part of the report discusses the implications of the findings and suggests directions for future research.

5. The fifth part of the report is a conclusion and a summary of the main findings.

6. The sixth part of the report is a list of references.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16391

## Certificate of Death

Reg. No.

|   |   |  |   |   |   |  |  |  |
|---|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Henry Thomas</b>                                 |  |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>18</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>7:00 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |  | 4c. County of Death  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-52-7153</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>12-31-50</b>   | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |
|   | Usual Residence of Decedent   |  |   |   |   |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>NA</b>               |   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>627 E. 34th Street Apt. #3-B</b>   |   |  |   | 10f. Zip Code<br><b>21218</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bus Driver</b>  |   | 16b. Kind of Business/Industry<br><b>Mass Transit Administration</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry L. Thomas, Sr.</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Powell</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sharon Thomas</b>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21218 627 E. 34th Street Baltimore, Maryland</b>   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cem. 05-24-99</b>   |   | 20c. Location - City or Town, State <b>MD Owings Mills</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or combination of diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>renal failure</b><br>Due to (or as a consequence of):<br>b. <b>hepatic encephalopathy</b><br>Due to (or as a consequence of):<br>c. <b>metastatic adenocarcinoma of the colon</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |   |   |  |  | Approximate Interval Between Onset and Death<br><b>1 month</b><br><b>1 month</b><br><b>1 year</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |   |  |   | 29c. License number<br><b>RES-000</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>May 18, 1999</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Matthews Chacko 601 North Wolfe Street Baltimore, Maryland 21287</b>   |   |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |   | 32. Registrar's Signature<br>          |   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16392

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Thomas</b>  |   |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>17</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>2:11 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sindi Hospital of Baltimore</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>n/a</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-14-0474</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 30 1925</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10e. State<br><b>Md.</b>  |   | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>1620 Marshall Street</b>   |   |   |  | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Police Officer</b>                                |  | 18b. Kind of Business/Industry<br><b>Baltimore, City</b>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Frank Thomas</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frieda Heffner</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Thomas (Son)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>100 Westview Drive, Shrewsbury, Penna. 17361</b>   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>   |  | Date<br><b>5/20/99</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Md.</b>                                 |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Christina A. Hutton</b>   |   |   |  | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home P.A.<br/>130 E. Fort Ave., Baltimore, Md. 21230</b>   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multisystem Organ Failure</b><br>Due to (or as a consequence of):<br><b>b. Sepsis</b><br>Due to (or as a consequence of):<br><b>c. Mycotic Aortic Aneurysm</b><br>Due to (or as a consequence of):<br><b>d. Prosthetic Aortic valve</b> |   |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>6 days</b><br><b>6 months</b><br><b>3 years</b>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease, Hypertension, Coagulopathy</b><br><b>Coronary Artery Bypass Graft 1996, Diabetes</b><br><b>Thyroid Disease</b>  |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day, Year)  |   | 28b. Time of injury<br><b>M</b>                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>MD.</b>   |   | 29c. License number<br><b>RES-000</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>May 17, 1999</b>                           |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>President M. J. J. M.D. 2401 W. Belvedere Ave 21215</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   | 32. Registrar's Signature<br><b>B. Sparks</b>   |   |  |  |  |  |  |

Pat. Known as, Thomas, Joseph

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16393

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Denis Henry Tierney, Sr.  |  |   |  | 2. Date of Death<br>Month Day Year<br>May 19, 1999  |  | 3. Time of Death<br>10:06pm                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Gilchrist Center  |  |   |  | 4b. City, Town, or Location of Death<br>Towson  |  | 4c. County of Death<br>Baltimore                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br>027-01-9198  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Nov 10, 1915              |  |
|   | 9. Birthplace (State or Foreign Country)<br>Canada  |  | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore  |  | 10c. City, Town or Location<br>Timonium                          |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>64 Cinder Road  |  | 10f. Zip Code<br>21093  |  | 10g. Citizen of What Country?<br>USA                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Edgewood Arsenal<br>Technical Publication- |  | 16b. Kind of Business/Industry<br>U.S. Government   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Edward Tierney   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gertrude Golding   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Ellen Ashton/Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>180 Cinder Road, Timonium, MD 21093  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Mem. Grdns. 5/24/99  |  | 20c. Location - City or Town, State<br>Timonium, Maryland   |  |  |  |
|   | 21. Signature of Funeral Service Licensed<br>Bryan W. Clary   |  | 22. Name and Address of Facility<br>Lemmon Funeral Home<br>10 W. Padonia Road, Timonium, MD 21093   |  |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>METASTATIC SMALL CELL LUNG CANCER<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |  |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension, Type II Diabetes, Ankylosing Spondylitis, ASCVD  |  |   |  |   |  |  |  |
|   | 23c. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice   |   |  |   |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>Patricia Savadel   |   |  |   | 29c. License number<br>D 27209   |   | 29d. Date signed (Month, Day, Year)<br>May 21, 1999                                  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Patricia Savadel, M.D. 1205 York Road, suite 18, Lutherville, MD 21093  |   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |   | 32. Registrar's Signature<br>B. Sparks   |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16394

## Certificate of Death

Reg. No.

|   |  |  |   |   |   |                                |  |   |  |  |
|---|--|--|---|---|---|--------------------------------|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Joseph Toney</u>  |  |   |   | 2. Date of Death<br>Month <u>05</u> Day <u>15</u> Year <u>1999</u>  |                                |  |   | 3. Time of Death<br><u>8 AM</u>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Bridgeway Manor Nursing Home</u>  |  |   |   | 4b. City, Town, or Location of Death<br><u>Catonsville</u>  |                                |  |   | 4c. County of Death<br><u>Baltimore</u>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>248-12-6499</u>  |  | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs., last birthday)<br><u>81</u> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><u>Aug. 15, 1917</u>  |   | 9. Birthplace (State or Foreign Country)<br><u>S. CAROLINA</u>                                 |  |
|   | Usual Residence of Decedent  |  |   |   |   |                                |  |   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><u>MD</u>  |  | 10b. County<br><u>Prince George</u>   |   | 10c. City, Town or Location<br><u>Capital Heights</u>   |                                |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br><u>1001 Cypressstree Pl.</u>   |  |   |   | 10f. Zip Code<br><u>20743-6313</u>  |                                | 10g. Citizen of What Country?<br><u>USA</u>  |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8th</u> College (1-4 or 5+) <u>Clergy</u>  |  |   |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Clergy</u>  |                                |  | 16b. Kind of Business/Industry<br><u>Religious</u>                      |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Jeff B. Toney</u>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Eloise Toney</u>  |                                |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><u>Nettie Toney</u>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1001 Cypressstree Pl., Capital Hts. Md 20743</u>  |                                |  |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Maryland National</u>  |   | Date<br><u>5/21/99</u>  |                                | 20c. Location - City or Town, State<br><u>Laurel, MD.</u>  |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><u>B. E. Taylor</u>   |  |   |   | 22. Name and Address of Facility<br><u>B. E. Taylor Funeral Services Inc.<br/>1722 North Capitol Street N.W.</u>  |                                |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Multiple Myeloma</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><u>Unknown</u> |  |   |   |   |                                |  |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Obstructive Cardiovascular Disease</u><br><u>Arteriosclerotic Coronary Vascular Disease</u>   |  |   |   |   |                                |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |                                |  |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><u>M</u>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><u>Michael Schaefer MD</u>   |   | 29c. License number<br><u>D19667</u>  |                                | 29d. Date signed (Month, Day, Year)<br><u>5/15/99</u>  |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Michael Schaefer MD 5517 A Ritchie Hwy. Balt. Md 21225</u>  |  |   |   |   |                                |  |   |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><u>MAY 21 1999</u>  |  |   |   | 32. Registrar's Signature<br><u>P. Sparks</u>   |                                |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16395

|  |   |                           |   |   |  |  |  |  |   |  |
|--|---|---------------------------|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Melva M. Vettters</b>                        |                           |   |   |  | 2. Date of Death<br>Month Day Year<br><b>May 13 1999</b> |  | 3. Time of Death<br><b>4:00 A.M.</b>   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>114 Burnett Street</b> |                           |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |  | 4c. County of Death<br><b>N/A</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>157 22 7637</b>   |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 29, 1927</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent   |                           |   |   |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>Baltimore</b> |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 10a. Street and Number<br><b>1835 S. Charles Street</b>  |   |                           |   |   | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+)   |   |                           |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert E. Lee</b>  |   |                           |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Tull</b>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Langrehr / daughter</b>   |   |                           |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1835 S. Charles Street Baltimore, Maryland 21230</b>   |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>   |   | Date<br><b>5/17/99</b>   |  | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Donna M. Zmironowski</i>   |   |                           |   |   | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CARCINOMA OVARY</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>2 MO</b> |   |                           |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                           |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|  |   |                           |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|  |   |                           |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) <b>Daughters Home</b> |   |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                           | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                           |  |
|  |   |                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                           | 29b. Signature and title of certifier<br><i>Mark Posner</i>   |   |  | 29c. License number<br><b>019640</b>                     |  | 29d. Date signed (Month, Day, Year)<br><b>5/20/99</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Mark Posner 1147 Hanover Street Baltimore, Maryland 21230</b>   |   |                           |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   |                           | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16396

## Certificate of Death

Reg. No.

|  |   |  |  |   |   |  |  |  |  |  |
|--|---|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Carrie Gilmore Worrell  |  |  |   | 2. Date of Death<br>Month Day Year<br>May 17, 99  |  |  |  | 3. Time of Death<br>6:55pm   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Forest Haven Nursing Home   |  |  |   | 4b. City, Town, or Location of Death<br>Catonsville   |  |  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-26-2417 A  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>86 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>02-01-13    |  | 9. Birthplace (State or Foreign Country)<br>SC   |  |
|  | Usual Residence of Decedent   |  |  |   |   |  |  |  |  |  |
| 10a. State<br>MD   |   | 10b. County<br>NA                      |  | 10c. City, Town or Location<br>Baltimore  |   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>5004 Chalgrove Avenue  |   |  |  | 10f. Zip Code<br>21215  |   |  |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3rd. Grade<br>College (14 or 5+) NA   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Custodian  |   |  |  | 16b. Kind of Business/Industry<br>Seton High   |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Gilmore   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louvenia Gilmore   |   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Leila Welch  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20747<br>2124 Harwood Road District Heights, Maryland  |   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Voshell Mem. Gardens   |   | Date<br>05-22-99  |  | 20c. Location - City or Town, State<br>Dundalk, MD |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Berna S. Johnson  |   |  |  | 22. Name and Address of Facility<br>Baltimore, Maryland 21202<br>WM.C.March F.H. 1101 E. North Avenue   |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u><br>Due to (or as a consequence of):<br>b. <u>DISEASE</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CHRONIC RENAL INSUFFICIENCY</u><br><u>HYPERTENSION</u>   |  |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year) |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Tasneem Lakhani   |   |  |  | 29c. License number<br>D28395   |   |  |  | 29d. Date signed (Month, Day, Year)<br>5/19/99   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTIMORE   |   |  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999   |   | 32. Registrar's Signature<br>B. Sparks |  |   |   |  |  |  |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16397

ITEM: #26 PER MD G771 5-21-99 WR.

## Certificate of Death

Reg. No.

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>RANDY</b>   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>12</b> Year <b>1999</b>  |   | 3. Time of Death<br><b>6:36 AM</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE Johns Hopkins Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore, City</b>   |   | 4c. County of Death<br><b>N/A</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-64-2348</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>8-22-1959</b> | 9. Birthplace (State or Foreign)<br><b>North Carolina</b>   |
|   | Usual Residence of Decedent  |  |  |   |   |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD.</b>   | 10b. County<br><b>N/A</b>  | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 10e. Street and Number<br><b>708 Wharton Court</b>   |  | 10f. Zip Code<br><b>21205</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>Goucher College</b> |   |   |
| To Be Completed by Physician/Medical Examiner | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>   |  | 16b. Kind of Business/Industry<br><b>Goucher College</b>   |   |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Henry Rodman</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn Wills</b>   |   |   |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn R. Wills (Mother)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>708 Wharton Court Balto., Md. 21205</b>          |   |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |   | 20c. Location - City or Town, State<br><b>5/17/99 Catonsville, Md.</b>  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Cable Funeral Service<br/>5502 Winner Ave. Balto., Md. 21215</b>  |   |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hyperkalemia</b><br>Due to (or as a consequence of):<br><b>b. End Stage Renal Stage</b><br>Due to (or as a consequence of):<br><b>c. Hypertension</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 23b. Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>6 months</b><br><b>10 years</b>  |  |  |   |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day, Year)   |  |  |   |   |
|   | 28b. Time of Injury<br><b>M</b>  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |
|   | 28d. Describe how injury occurred  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |
|   | 29b. Signature and title of certifier<br>  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D52183</b>   |  |  |   |   |
|   | 29d. Date signed (Month, Day, Year)<br><b>May 12, 1999</b>   |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Hunter Young MD Room 9020 1830 Building 1830 Monument St Baltimore MD</b>  |  |  |   |   |
|   | 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br>  |  |  |   |   |
|   | 33. State Registrar<br><b>State Registrar</b>  |  |  |   |   |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16398

ITEM: #24A PER MEO G771 5-21-99 WR.

## Certificate of Death

Reg. No.

|   |   |   |  |   |   |  |  |  |
|---|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>George Waters</i>                            |   |  |   | 2. Date of Death<br>Month Day Year<br>May 1 1999  |  | 3. Time of Death<br>10:20 pm                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Millennium at South River |   |  |   | 4b. City, Town, or Location of Death<br>Edgewater |  | 4c. County of Death<br>Anne Arundel                  |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-32-6663  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>64 Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 12, 1934 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | 10a. State<br>Maryland   |   | 10b. County<br>Anne Arundel                       |  | 10c. City, Town or Location<br>Edgewater             |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>144 Washington Road   |  | 10f. Zip Code<br>21037  |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify:<br>unknown |   | 14. Race - American Indian, Black, White, etc.<br>Specify: black                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unknown unknown   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer  |  | 16b. Kind of Business/Industry<br>Farming   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>William Waters   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>unknown   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>unknown  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>in state  |  | 20c. Location - City or Town, State   |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Ronald S. Wade</i> Ronald S. Wade, Director   |   |   |  | 22. Name and Address of Facility<br>State Anatomy Board, 655 W. Baltimore Street<br>Baltimore, MD 21201   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Autistic Brain C</i><br>Due to (or as a consequence of):<br><i>lung C (primary)</i><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>COPD</i>   |   |   |  |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |  | 29c. License number<br>D27564   |   | 29d. Date signed (Month, Day, Year)<br>5/7/99  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Allen Hettlemann 1838 Greene Tree Rd #300</i>  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 21 1999  |   | 32. Registrar's Signature<br><i>[Signature]</i> B. Sparks   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16399

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |  |  |   |  |
|---|--|---|--|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Brenda White</i>  |   |  |   | 2. Date of Death<br>Month <i>5</i> Day <i>14</i> Year <i>99</i> |  |  |  | 3. Time of Death<br><i>4:15 Am</i>                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>University of Maryland Medical System</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>Baltimore</i>        |  |  |  | 4c. County of Death<br><i>Baltimore City</i>          |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>217-66-3792</i>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><i>41</i> Yrs.                |  | 8. Date of Birth (Month, Day, Year)<br><i>4-4-1958</i> |  | 9. Birthplace (State or Foreign Country)<br><i>Va</i> |  |
|   | Usual Residence of Decedent  |   |  |   | 10a. State<br><i>md</i>   |  | 10b. County<br><i>NA</i>                               |  | 10c. City, Town or Location<br><i>Baltimore</i>       |  |
| 10e. Street and Number<br><i>524 N. Brice Street</i>  |  | 10f. Zip Code<br><i>21223</i>   |  | 10g. Citizen of What Country?<br><i>U. S.A</i>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                        |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th grade</i> College (1-4or 5+) <i>NA</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Day Care</i>  |  | 16b. Kind of Business/Industry<br><i>Home</i>   |   |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><i>Cecil M. White</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Pauline Holley</i>  |   |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Chanda White - Daughter</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>524 N. Brice Street Balto, Md 21223</i>   |   |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>King Memorial Park</i>   |  | 20c. Location - City or Town, State<br><i>5-20-99 Randallstown, Md</i>  |   |  |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Bladys Warner</i>   |  |   |  | 22. Name and Address of Facility<br><i>March F. H. West<br/>4300 Wabash Avenue Balto, Md 21215</i>  |   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <i>Hepatitis Not otherwise specified</i><br>Due to (or as a consequence of):<br>b. <i>Hemorrhagic Pancreatitis</i><br>Due to (or as a consequence of):<br>c. <i>Adult respiratory distress syndrome</i><br>Due to (or as a consequence of):<br>d. <i>Hepato renal syndrome</i> |  |   |  | Approximate Interval Between Onset and Death  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |   |  |
|   |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><i>M</i>  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of certifier<br><i>[Signature]</i> MD  |  |   |   | 29c. License number<br><i>P11216</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>5/14/99</i>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Michael C. Banks 10 S. Green St. Baltimore, Md 21201</i>   |  |   |  | 31. Date filed (Month, Day, Year)<br><i>MAY 21 1999</i>   |   |  |  | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Natural" or Items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16400

|   |   |   |  |  |  |  |  |   |
|---|---|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CATHERINE M WHEATLEY</b>                       |   |  |  | 2. Date of Death<br>Month <b>05</b> Day <b>18</b> Year <b>99</b> |  | 3. Time of Death<br><b>12 PM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CHURCH HOME HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>    |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-10-3410</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.   | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>3/13/04</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>HILLENDALE</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1236 DEANWOOD ROAD</b>   |   |   |  | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th GRADE</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MACHINE OPERATOR</b>   |  |  | 16b. Kind of Business/Industry<br><b>PRINTING CO.</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN HILBINGER</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FANNY NILY</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY F. BOCK NIECE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1236 DEANWOOD ROAD BALTIMORE, MD 21234</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEM.</b>  |  | Date<br><b>5/22/99</b>   |  | 20c. Location - City or Town, State<br><b>PARKVILLE, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>   |  |  |  |   |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>Due to (or as a consequence of):<br><b>b. CANCER BREAST</b><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                           |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |   |  | 29c. License number<br><b>D38033</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/18/99</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>101 N. BOND STREET BALTIMORE, MD 21231</b>   |   |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16401

|  |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
|--|---|---|--|--|--|---|--|----------------------|--|----------------------|---|-----------------|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Emma N. Whittington</b>                  |   | 2. Date of Death<br>Month <b>May</b> Day <b>17</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>01:17am</b>           |   |  |                      |  |                      |   |                 |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Mercy Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>City</b>           |   |  |                      |  |                      |   |                 |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-18-6298</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>95</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.               |   |  |                      |  |                      |   |                 |    |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>June 18, 1903</b>                             |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |   |  |                      |  |                      |   |                 |    |  |
| Usual Residence of Decedent  |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |   |  |                      |  |                      |   |                 |    |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 10e. Street and Number<br><b>1611 Clarkson Street</b>  |   |   | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b> |   |  |                      |  |                      |   |                 |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  |                      |  |                      |   |                 |    |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |                      |  |                      |   |                 |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Harrison</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie James</b>   |  |  |   |  |                      |  |                      |   |                 |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Clyde Shiflett / Son</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1611 Clarkson Street Baltimore, Maryland 21230</b> |  |  |   |  |                      |  |                      |   |                 |    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oedar Hill Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |  |   |  |                      |  |                      |   |                 |    |  |
| 21. Signature of Funeral Service Licensee<br><b>Donna Zramkowski</b>   |   | 22. Name and Address of Facility<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Maryland 21225</b>   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Multi organ System Failure</b><br/>Due to (or as a consequence of):</td> <td><b>&lt; 24 hours</b></td> </tr> <tr> <td>b. <b>Sepsis</b><br/>Due to (or as a consequence of):</td> <td><b>&lt; 24 hours</b></td> </tr> <tr> <td>c. <b>Left lower lobe pneumonia</b><br/>Due to (or as a consequence of):</td> <td><b>one week</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>Multi organ System Failure</b><br>Due to (or as a consequence of): | <b>&lt; 24 hours</b> | b. <b>Sepsis</b><br>Due to (or as a consequence of): | <b>&lt; 24 hours</b> | c. <b>Left lower lobe pneumonia</b><br>Due to (or as a consequence of): | <b>one week</b> | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <b>Multi organ System Failure</b><br>Due to (or as a consequence of):                | <b>&lt; 24 hours</b>  |  |  |  |   |  |                      |  |                      |   |                 |    |  |
|  | b. <b>Sepsis</b><br>Due to (or as a consequence of):                                    | <b>&lt; 24 hours</b>  |  |  |  |   |  |                      |  |                      |   |                 |    |  |
|  | c. <b>Left lower lobe pneumonia</b><br>Due to (or as a consequence of):                 | <b>one week</b>   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
|  | d.  |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |                      |  |                      |   |                 |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>renal failure - chronic</b><br><b>atrial fibrillation - chronic</b>   |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  |   |  |                      |  |                      |   |                 |    |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 29b. Signature and title of certifier<br><b>Karen M. Korzick, MD</b>   |   | 29c. License number<br><b>D40744</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 17, 1999</b>   |  |   |  |                      |  |                      |   |                 |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K.A. Korzick, MD 301 So. Paul Pl. Baltimore MD 21202</b>  |   |   |  |  |  |   |  |                      |  |                      |   |                 |    |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>  |   | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |  |   |  |                      |  |                      |   |                 |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16402

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Franklin Carroll Young</b>                      |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MAY 15, 1999</b> |  | 3. Time of Death<br><b>22:02 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHN HOPKINS HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-72-8134</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth (Month, Day, Year)<br><b>12 09 58</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>M.D.</b>  |
|   | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1205 Washington Street</b>   |  |   |  | 10f. Zip Code<br><b>21213</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>na</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accounting Dept.</b>  |   |  | 16b. Kind of Business/Industry<br><b>Baltimore City</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Nathaniel Young</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruby Motley</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruby Young</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5408 Denmore Ave, Baltimore Md 21215</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt Zion Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Md</b>  |  | Date<br><b>5/21/99</b>   |
| 21. Signature of Funeral Service Licensee<br><i>Shannon Stokes</i>  |  |   |  | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore Md 21215</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Blunt force Head Injuries</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |   |  |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day, Year)<br><b>5-15-99</b>  |   | 28b. Time of Injury<br><b>21:26 M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |  | 28d. Describe how injury occurred<br><b>subject beaten</b>  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1200 N. Collington Ave</b>  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 16, 1999</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Diana R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 21 1999</b>   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16403

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Anderson

2. Date of Death

Month  
AprilDay  
26Year  
1999

3. Time of Death

8:00pm

4a. Facility Name (If not institution, give street and number)

MANOR CARE SILVER SPRING

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

229-05-7143

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

AUGUST 17, 1921

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

WASHINGTON, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

118 17TH STREET N.E.

10f. Zip Code

20002

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

ALEXANDER SELLERS

18. Mother's Name (First, Middle, Maiden Surname)

JENNIE GREEN

19a. Informant's Name/Relationship (Type, Print)

IVY YORK DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10827 VALLEY HILLS DRIVE, HOUSTON TEXAS 77071

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

5-4-99

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Ramon Dutierrez MO0907

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME INC.  
3401 BLADENSBURG RD, BRENTWOOD MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Hepatoma

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jenny Y. May MD

29c. License number

D43260

29d. Date signed (Month, Day, Year)

April 26, 1999

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

13952 Baltimore Ave Laurel MD 20707

31. Date filed (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amended #7 and  
Amended #8, 5/10/99, Howard Co., M.W.O.

99 16404

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Marie Arnold

2. Date of Death

Month  
May 3, 1999Day  
Year

3. Time of Death

6:50 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

5. Social Security Number

218-24-0670

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

77 78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 1, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

400 Carroll Avenue

10f. Zip Code

20707

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Carl Lang

18. Mother's Name (First, Middle, Maiden Sumama)

Marie Merson

19a. Informant's Name/Relationship (Type, Print)

Diane Lang / niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

405 Apt. F Old Stage Road Glen Burnie, Md. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ivy Hill Cemetery

Date

May

20c. Location - City or Town, State

6, 1999 Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.  
313 Talbott Avenue Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

5 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Aortic stenosis

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure

Vasculitis

Bacteremia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43237

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16405

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BENJAMIN FRANKLIN ALLISON, JR.</b>           |   | 2. Date of Death<br>Month Day Year<br><b>MAY 5, 1999</b>          |  | 3. Time of Death<br><b>9:17 AM</b>         |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>8351 SYCAMORE ROAD</b> |   | 4b. City, Town, or Location of Death<br><b>MILLERSVILLE</b>       |  | 4c. County of Death<br><b>ANNE ARUNDEL</b> |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-50-9127</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.                  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.             |
|  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 5, 1947</b>                                  |   | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b> |  |  |
| Usual Residence of Decedent  |   |   |   |  |  |
| 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>ANNE ARUNDEL</b>  |   | 10c. City, Town or Location<br><b>MILLERSVILLE</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |  |  |
| 10e. Street and Number<br><b>8351 SYCAMORE ROAD</b>  |   | 10f. Zip Code<br><b>21108</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>WELL DRILLER/SERVICE</b>  |   | 16b. Kind of Business/Industry<br><b>WELLS</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>BENJAMIN F. ALLISON, SR.</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY WILSON</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>APRIL ALLISON (WIFE)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8351 SYCAMORE ROAD, MILLERSVILLE, MARYLAND 21108</b>  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>   |   | 20c. Location - City or Town, State<br><b>5/8/99 GLEN BURNIE, MD.</b>  |  |
| 21. Signature of Federal Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Colon Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | Approximate Interval Between Onset and Death<br><b>2 yrs</b>   |  |
| 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>D39505</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>May 6, 1999</b>  |   |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Yudhish Markan 1600 Crain Hwy #602 Glen Burnie, MD 21061</b>  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16406

|  |   |   |  |   |   |  |  |   |
|--|---|---|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Eugenia Schor Andris                                    |   |  |   | 2. Date of Death<br>Month Day Year<br>May 5, 1999   |  | 3. Time of Death<br>11:00 am   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>4620 North Park Avenue # 807 East |   |  |   | 4b. City, Town, or Location of Death<br>Chevy Chase |  | 4c. County of Death<br>Montgomery  |   |
| Funeral<br>Director  | 5. Social Security Number<br>341-07-9149  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>89 Yrs.   | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Aug. 11, 1910   | 9. Birthplace (State or Foreign Country)<br>Maryland  |
|  | Usual Residence of Decedent   |   |  |   | 10c. City, Town or Location<br>Chevy Chase          |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 10a. State<br>Maryland   |   | 10b. County<br>Montgomery   |  | 10f. Zip Code<br>20815  |   | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 4  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Public Relations/Advocate  |   | 16b. Kind of Business/Industry<br>Private  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Williams Schor-Son  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Clio Joanides  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Leon Andris  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8030 Woodmont Avenue, Suite 300 Bethesda, MD 20814   |   |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Crematory  |   | 20c. Location - City or Town, State<br>5-7-99 Brentwood, Maryland  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Lisa S. Johnson</i>  |   |   |  | 22. Name and Address of Facility<br>Fort Lincoln Funeral Home<br>3401 Bladensburg Road, Brentwood, Maryland 20722   |   |  |  |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Respiratory Arrest<br>Due to (or as a consequence of):<br><br>b. Chronic Obstruction Pulmonary Disorder<br>Due to (or as a consequence of):<br><br>c. Alzheimer's Dementia<br>Due to (or as a consequence of):<br><br>d. |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|  |   |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |   |   |  |  |   |
| 29b. Signature and title of certifier<br><i>Dr. L. McConnell</i>   |   |   |  | 29c. License number<br>037452   |   | 29d. Date signed (Month, Day, Year)<br>5/4/99  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. L. McConnell 5530 Wisconsin Ave #930 Chevy Chase   |   |   |  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>MAY 07 1999   |   |   |  | 31. Registrar's Signature<br><i>B. [Signature]</i>  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Department of the Interior

Washington, D. C.

October 1, 1910

Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the proper authorities.

I am, Sir, very respectfully,  
Yours very truly,

Wm. H. Wood

Chief of Bureau

Department of the Interior

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16407

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Mary Ellen Blanks  
2. Date of Death Month Day Year APRIL 27, 1999  
3. Time of Death 1528

Funeral  
Director

4a. Facility Name (If not institution, give street and number) MALCOLM GROW AFB HOSPITAL  
4b. City, Town, or Location of Death CAMP SPRINGS  
4c. County of Death PRINCE GEORGES

5. Social Security Number 577-62-1819  
6. Sex 1 ☐ M 2 ☒ F  
7. Age (In yrs. last birthday) 51 Yrs.  
8. Date of Birth (Month, Day, Year) July 8, 1947  
9. Birthplace (State or Foreign Country) North Carolina

Usual Residence of Decedent

10a. State Maryland  
10b. County Prince George's  
10c. City, Town or Location District Heights  
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 2504 Edfeldt Drive  
10f. Zip Code 20747  
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crossing Guard  
16b. Kind of Business/Industry D.C. Police

17. Father's Name (First, Middle, Last) John Jenkins  
18. Mother's Name (First, Middle, Maiden Surname) Dora M. Jenkins

19a. Informant's Name/Relationship (Type, Print) Erica M. Adams (Daughter)  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Edfeldt Drive District Heights, Maryland 20747

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  
20b. Place of Disposition (Name of cemetery, crematory or other place) National Harmony Memorial Park  
20c. Location - City or Town, State Landover, Maryland  
20d. Date 5/1/99

21. Signature of Funeral Service Licensee [Signature]  
22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  
Due to (or as a consequence of):  
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {  
Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS  
23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No  
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? 1 ☐ Yes 2 ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] M.D.  
29c. License number D33954  
29d. Date signed (Month, Day, Year) APRIL 28 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLIG JR MD 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year) MAY 04 1999  
32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

11



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 99 16408

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John McComas Baer Jr.

2. Date of Death

Month  
MayDay  
11Year  
1999

3. Time of Death

7:32 P.M.

4a. Facility Name (If not institution, give street and number)

13001 B Martin Rd.

4b. City, Town, or Location of Death

Smithsburg

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

216-30-3653

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 20, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Smithsburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13001 B Martin Rd.

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Truck Co.

17. Father's Name (First, Middle, Last)

John M. Bear Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Hattie M. Eccard

19a. Informant's Name/Relationship (Type, Print)

Lorraine A. Harne (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13123 Martin Rd. Smithsburg, Md. 21783

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salem U.M. Cemetery May 14, 1999

Date

20c. Location - City or Town, State

Wolfsville, Md.

21. Signature of Funeral Service Licensee

Hennis R. Davis

22. Name and Address of Facility

Davis Funeral Home  
12525 Bradbury Ave.  
Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bladder cancer.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval between Onset and Death

1 year.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic lymphocytic leukemia  
congestive heart failure  
chronic emphysema.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Hind Hamdan MD

29c. License number

DH6473

29d. Date signed (Month, Day, Year)

5/13/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

MAY 14 1999

32. Registrar's Signature

A. Spahr

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

3. Time of Death  
11:30 p.m.Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sylvia Pearl BALTHUS

2. Date of Death

May 11 1999

3. Time of Death

11:30 p.m.

4a. Facility Name (If not institution, give street and number)

1404 Salem Avenue

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

220-16-0903

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 24 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1404 Salem Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

X-Ray Film Clerk

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

John Wesley Hixon

18. Mother's Name (First, Middle, Maiden Surname)

Margie Ellen Allen

19a. Informant's Name/Relationship (Type, Print)

Wesley Balthus - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12364 Harvey Road Clear Spring, Maryland 21722

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rest Haven Cemetery

Date

5/15/99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

041667

29d. Date signed (Month, Day, Year)

5.13.99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael J. McCormick 1110 Medical Campus Rd Suite 130 Hagerstown MD 21740

31. Date filed (Month, Day, Year)

MAY 13 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |  |  |  |
|--|--|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Hilda Alliene Berry  |  |   |   |  | 2. Date of Death<br>Month Day Year<br>May 10 1999  |  | 3. Time of Death<br>1440   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital   |  |   |   |  | 4b. City, Town, or Location of Death<br>Hagerstown   |  | 4c. County of Death<br>Washington County                         |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-24-9475   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>68 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 28, 1930   |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |  | 10b. County<br>Washington Co.   |   | 10c. City, Town or Location<br>Hagerstown  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|  | 10e. Street and Number<br>14727 Daly Road  |  |   |   | 10f. Zip Code<br>21740   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+) 0  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nursing Assistant  |   |  | 16b. Kind of Business/Industry<br>Nursing Home   |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Solomon Lewis Faulders  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Esta May Reynolds   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Donna Jean Daley/Daughter  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742<br>1430 Kensington Dr., Apt. 103, Hagerstown, Maryland |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery |  | Date<br>May 13   |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland      |  |  |
|  | 21. Signature of Funeral Service Licenses<br><i>Douglas A. Fiery</i>   |  |   |   |  | 22. Name and Address of Facility<br>Douglas A. Fiery Funeral Home<br>1331 Eastern Blvd., N., Hagerstown, Maryland 21742                                    |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <i>liver metastasis</i><br>Due to (or as a consequence of):<br>b. <i>Breast cancer</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |  | 4 months<br>29 months                        |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|  |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                    |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  | 29b. Signature and title of certifier<br><i>Hind Hamdan</i>   |   |  | 29c. License number<br>D46473  |  | 29d. Date signed (Month, Day, Year)<br>5/11/99                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740.   |  |  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 12 1999   |  |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16411

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mildred Gertrude Brown</b>                  |   |  |  | 2. Date of Death<br>Month <b>May</b> Day <b>09</b> Year <b>99</b> |  | 3. Time of Death<br><b>10:45pm (2245 hrs)</b>                |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1232 Eleanor Lane</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>         |  | 4c. County of Death<br><b>Washington County</b>              |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-76-2635</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.   | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 21, 1913</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|  | Usual Residence of Decedent  |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington Co.</b>  |  | 10c. City, Town or Location<br><b>Hagerstown</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 10e. Street and Number<br><b>1232 Eleanor Lane</b>   |  |   |  | 10f. Zip Code<br><b>21742</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank M. Feustle</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillian D. Brown</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara A. Brown/Daughter-in-law</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1232 Eleanor Lane, Hagerstown, Maryland 21742</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakeview Cemetery</b>  |  | Date<br><b>May 11</b>  |   | 20c. Location - City or Town, State<br><b>Sykesville, Maryland</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Douglas A. Fiery</i>   |  |   |  | 22. Name and Address of Facility<br><b>Douglas A. Fiery Funeral Home<br/>1331 Eastern Blvd., N., Hagerstown, Maryland 21742</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Cerebrovascular Disease</b><br>Due to (or as a consequence of):<br>b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d. <b>Malnutrition</b> |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><br><b>9 years</b><br><br><b>3 mos</b><br><br><b>10 years</b><br><br><b>3 mos</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Howleem</i>   |  | 29c. License number<br><b>D50738</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/11/99</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sandra Tower MD 239 N. Potomac St. Hagerstown, MD 21740</b>   |  |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 12 1999</b>  |  | 32. Registrar's Signature<br><i>S. Sparks</i>   |  |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16412

|  |   |  |  |  |  |  |   |  |
|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Fred Vernon BARNHART  |  |  |  | 2. Date of Death<br>Month Day Year<br>May 09 1999  |  | 3. Time of Death<br>0750  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Hagerstown   |  | 4c. County of Death<br>Washington   |  |
| Funeral<br>Director  | 5. Social Security Number<br>179-30-3623  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>Yrs. 71  |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 29, 1927  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Needmore, Pa.   |  | 10a. State<br>Maryland   |  | 10b. County<br>Washington  |  | 10c. City, Town or Location<br>Sharpsburg   |  |
| To Be Completed by<br>Funeral Director                                       | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>6821 Sharpsburg Pike   |  | 10f. Zip Code<br>21782   |  | 10g. Citizen of What Country?<br>USA  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1952-54  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white  |  |
| To Be Completed by<br>Physician/Medical Examiner                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) 0   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>farmer  |  | 16b. Kind of Business/Industry<br>dairy farm   |  | 17. Father's Name (First, Middle, Last)<br>Alonzo Barnhart  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha unknown   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Janice E. Price - wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6821 Sharpsburg Pike, Sharpsburg, Md. 21782   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Lawn Memorial Park  |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |  | 21. Signature of Funeral Service Licensee<br>Scott Minnich   |  | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Ischemic Cardiomyopathy<br>Due to (or as a consequence of):<br>c. Atherosclerotic coronary artery disease<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Approximate Interval Between Onset and Death<br>Several Years |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus<br>Chronic Renal Insufficiency  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner                             | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>Dr. T. Delapontas  |  |
| State<br>Registrar   | 29c. License number<br>D26523   |  | 29d. Date signed (Month, Day, Year)<br>May 9 1999  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. T. DELAPONTAS 1110 MEDICAL CAMPUS ROAD<br>HAGERSTOWN MD 21742  |  | 31. Data filed (Month, Day, Year)<br>MAY 11 1999  |  |
|  | 32. Registrar's Signature<br>S. Sparks  |  |  |  |  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16413

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Robert William BARNHART II                           |  |  |  | 2. Date of Death<br>Month Day Year<br>May 7, 1999  |  | 3. Time of Death<br>4:20am                           |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>1119 Carroll Heights Boulevard |  |  |  | 4b. City, Town, or Location of Death<br>Hagerstown |  | 4c. County of Death<br>Washington                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>164-34-2077   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>55 Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 16, 1943 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland   |  | 10b. County<br>Washington                          |  | 10c. City, Town or Location<br>Hagerstown            |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>1119 Carroll Heights Boulevard   |  | 10f. Zip Code<br>21740   |  | 10g. Citizen of What Country?<br>USA   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 0   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>environmental consultant  |  | 16b. Kind of Business/Industry<br>environmental  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Merle Barnhart  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Geraldine Wolfensberger   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Joleen F. Barnhart - wife  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1119 Carroll Heights Blvd., Hagerstown, Md. 21740   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hagerstown Crematory   |  | Date<br>5-8-99   |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnich</i>   |  |  |  | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | a. <i>Esophageal Adenocarcinoma</i><br>Due to (or as a consequence of):  |  | b.<br>Due to (or as a consequence of):   |  | c.<br>Due to (or as a consequence of):   |  | d.<br>Due to (or as a consequence of): |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                 |  | 29b. Signature and title of certifier<br><i>Hind Hamdan MD</i>   |  | 29c. License number<br>D46473  |  | 29d. Date signed (Month, Day, Year)<br>5/7/99  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Hind Hamdan, MD, 363 S. Cleveland Ave; Hagerstown, MD 21740  |  | 31. Date filed (Month, Day, Year)<br>MAY 07 1999   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



77

603-21-0

received

received

received

received

X

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

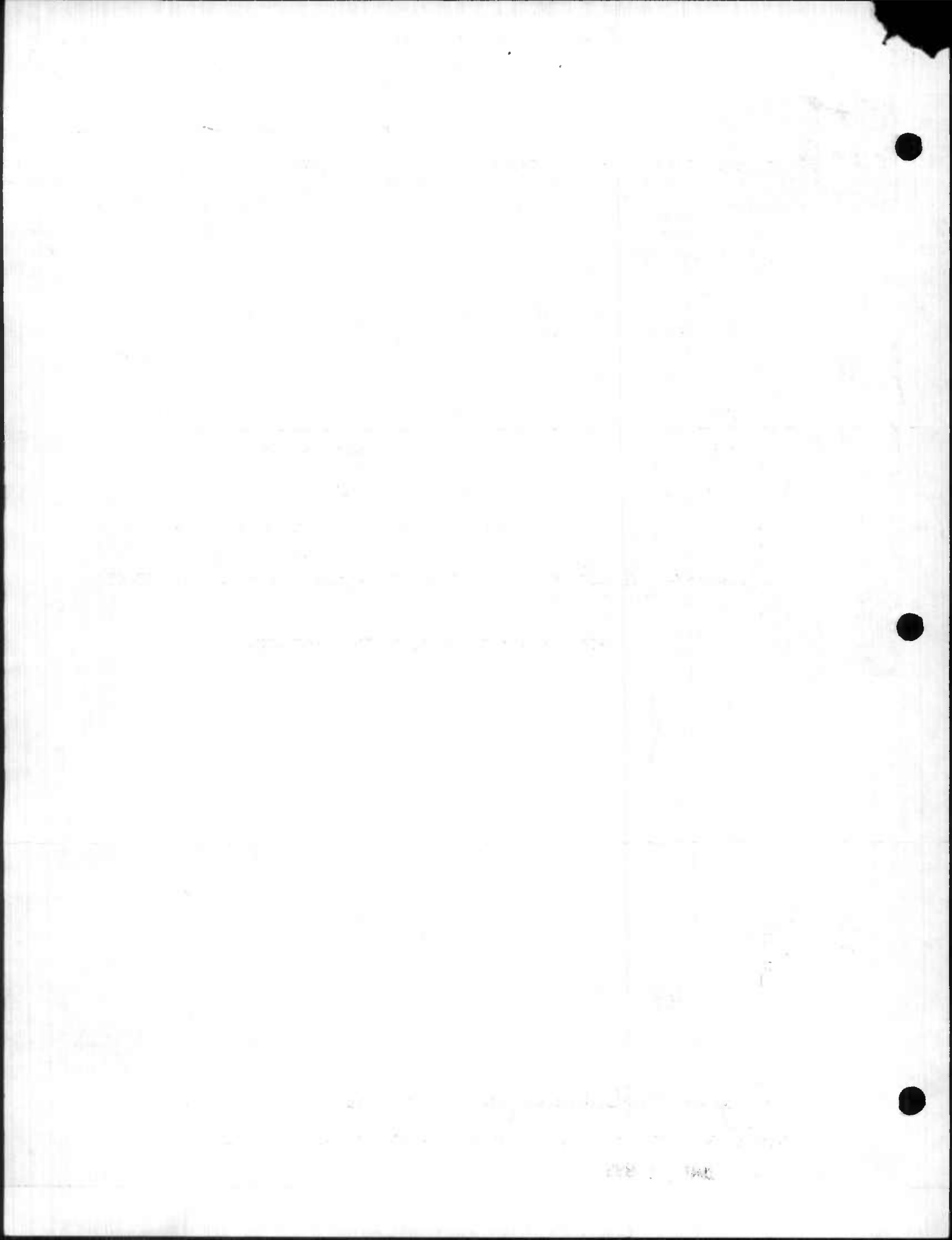
AMENDED #2, WCHD-05/13/99, EPW

99 16414

|  |   |  |                                 |   |   |                                 |   |   |
|--|---|--|---------------------------------|---|---|---------------------------------|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RILEY S BULL</b>   |  |                                 |   | 2. Date of Death<br>Month <b>05</b> Day <b>07</b> Year <b>99</b>  |                                 | 3. Time of Death<br><b>1818</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |  |                                 |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>  |                                 | 4c. County of Death<br><b>WICOMICO</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>230-56-8026</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>10-3-42</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
|  | Usual Residence of Decedent   |  |                                 |   | 10a. State<br><b>Virginia</b>   |                                 | 10b. County<br><b>Accomack</b>  |   |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>Horsey</b>  |  |                                 |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |                                 | 10e. Street and Number<br><b>Horsey Road</b>  |   |
|  | 10f. Zip Code<br><b>23396</b>   |  |                                 |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |                                 | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced |   |
|  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  |                                 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |  |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>technician</b>                    |                                 | 16b. Kind of Business/Industry<br><b>N.A.S.A.</b>   |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Paul Bull</b>   |  |                                 |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Shreaves</b>   |                                 |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Shelton Bull</b>  |  |                                 |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Horsey Road -- Oak Hall, VA 23416</b>         |                                 |   |   |
|  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Edge Hill Cemetery</b>   |                                 | 20c. Location - City or Town, State<br><b>5-10-99 Accomac VA</b>                                    |   |
|  | 21. Signature of Funeral Service Licensee<br><i>James N. Lat</i>  |  |                                 |   | 22. Name and Address of Facility<br><b>Fox Funeral Home</b><br><b>PO Box 278 - Temperanceville VA 23442</b>                                       |                                 |   |   |
|  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                                 |   | Approximate interval Between Onset and Death  |                                 |   |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                 |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                             |                                 |   |   |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |   |  |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |   |                                 |   |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |   |  |                                 | 26. Place of Death (Check only one)<br>Hospice: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |                                 |   |   |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |   |  |                                 | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b> |   |   |
| 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No   |   |  |                                 | 28d. Describe how injury occurred   |   |                                 |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                                 |   |   |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |                                 | 29b. Signature and title of certifier<br><i>John T. Bulkeley, M.D.</i>  |   |                                 |   |   |
| 29c. License number<br><b>D0003599</b>   |   |  |                                 | 29d. Date signed (Month, Day, Year)<br><b>05-10-99</b>  |   |                                 |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801</b>   |   |  |                                 | 31. Date filed (Month, Day, Year)<br><b>MAY 12 1999</b>   |   |                                 |   |   |
| 32. Registrar's Signature<br><i>Barbara B. Sparks</i>  |   |  |                                 |   |   |                                 |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16415  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Ballard

2. Date of Death

05 04 99

3. Time of Death

0320

4a. Facility Name (If not institution, give street and number)

Water View Nursing Home

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

220-32-1210

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs

Hours Min.

8. Date of Birth (Month, Day, Year)

10-03-18

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

md

10b. County

Worcester

10c. City, Town or Location

Pocomoke

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

129 Wallop &amp; Taylor Rd

10f. Zip Code

21851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Farm work

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

Lottie Kirkwood

19a. Informant's Name/Relationship (Type, Print)

Lottie Ballard daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

129 Wallop &amp; Taylor Rd Pocomoke, md 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Tinsley mem.

Date

5/8/99 Pocomoke, md

20c. Location - City or Town, State

Pocomoke, md

21. Signature of Funeral Service Licensee

Samuel J. Savage

22. Name and Address of Facility

22171 Wharton Rd Pocomoke, VA 23301

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral infarct

Due to (or as a consequence of):

md.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Arterial hypertension

Due to (or as a consequence of):

ger.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF, CAD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Robins

29c. License number

029349

29d. Date signed (Month, Day, Year)

5/4/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1104 Healthway Dr. Salisbury, MD 21801

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16416

Certificate of Death

Reg. No.

|   |   |   |  |   |  |                          |  |  |  |  |  |
|---|---|---|--|---|--|--------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Gregory Michael Braun                   |   |  |   | 2. Date of Death<br>Month Day Year<br>April 24, 1999 |                          |  |  | 3. Time of Death<br>8:45 PM                          |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>211 Dominion Road |   |  |   | 4b. City, Town, or Location of Death<br>Chester      |                          |  |  | 4c. County of Death<br>Queen Anne's                  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-72-2151  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>42 Yrs.            |                          | 8. Date of Birth (Month, Day, Year)<br>July 15, 1956 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|   | Usual Residence of Decedent   |   |  |   |  |                          |  |  |  |  |  |
| 10a. State<br>MD  |   | 10b. County<br>Queen Anne's   |  | 10c. City, Town or Location<br>Chester  |  |                          |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 10e. Street and Number<br>211 Dominion Road   |   |   |  | 10f. Zip Code<br>21619  |  |                          |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter  |  |                          |  | 16b. Kind of Business/Industry<br>Maintenance  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Paul F. Braun Sr.  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary V. Koors  |  |                          |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mary Quinn - Sister   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>106 Margaret Drive, Stevensville, MD 21666   |  |                          |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Stevensville Cemetery   |  |                          |  | 20c. Location - City or Town, State<br>Stevensville, MD  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Chad M. Helfenbein   |   |   |  | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>106 Shamrock Road, Chester, MD 21619   |  |                          |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Lung Cancer<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |  |   |  |                          |  |  |  | Approximate Interval Between Onset and Death<br>Months     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |                          |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   |   |   |  |   |  |                          |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   |   |   |  |   |  |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                          |  |
|   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |   |  |                          |  |  |  | 29b. Signature and title of certifier<br>James Chaconas MD |  |
|   |   |   |  | 29c. License number<br>D16964   |  |                          |  | 29d. Date signed (Month, Day, Year)<br>4/26/99   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>James Chaconas 1505 Rutledge Hwy Annapolis, Md 21012  |   |   |  |   |  |                          |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 27 1999  |   |   |  | 32. Registrar's Signature<br>B. Sparks  |  |                          |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16417

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |   |  |                                |  |  |
|--|--|---|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Catherine Adelia BROWN   |  |   |   | 2. Date of Death<br>Month Day Year<br>March 31, 1999   |                                | 3. Time of Death<br>10:08 A.M.   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Corsica Hills-Genesis Eldercare  |  |   |   | 4b. City, Town, or Location of Death<br>Centreville  |                                | 4c. County of Death<br>Queen Anne's  |  |
| 5. Social Security Number<br>219-12-7757   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>Yrs. 75 | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>June 9, 1923  |  |
| 9. Birthplace (State or Foreign Country)<br>Baltimore, MD  |  |   |   |  |                                |  |  |
| Usual Residence of Decedent  |  |   |   |  |                                |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Queen Anne's   |   | 10c. City, Town or Location<br>Chester   |                                | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 10e. Street and Number<br>3 Sherman Way  |  |   |   | 10f. Zip Code<br>21619   |                                | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |                                | 16b. Kind of Business/Industry<br>Self   |  |
| 17. Father's Name (First, Middle, Last)<br>William Brown   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Sherbert   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mollie Clark - Daughter  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 Sherman Way, Chester, MD 21619  |                                |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Cremation Center LLC.  |   | Date<br>April 1, 1999  |                                | 20c. Location - City or Town, State<br>Stevensville, MD  |  |
| 21. Signature of Funeral Service Licensee<br><i>Cheryl Hefley</i>  |  |   |   | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>106 Shamrock Road, Chester, MD 21619  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |   |  |                                |  | Approximate Interval Between Onset and Death<br>5 yr |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |  |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |   |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of Certifier<br><i>Gay J. Spruce</i>   |   |  |                                |  |  |
|  |  | 29c. License number<br>032036   |   | 29d. Date signed (Month, Day, Year)<br>3/31/99   |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gay J. Spruce 2107 D. Smith Drive Chester, MD 21619  |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 01 1999   |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16418

|  |  |  |   |  |   |  |   |   |  |  |
|--|--|--|---|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Gerald Botticelli</b>   |  |   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 21 1999</b>                                  |   | 3. Time of Death<br><b>10 30 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Howard County General Hospital Columbia</b> |  |   |  |   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>                                     |   | 4c. County of Death<br><b>Howard</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>123-44-2047</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>January 13, 1951</b>                              |   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                    |  |
|  | Usual Residence of Decedent  |  |   |  |   |  |   |   |  |  |
| 10a. State<br><b>Maryland</b>  |  |  | 10b. County<br><b>Howard</b>  |  |   | 10c. City, Town or Location<br><b>Columbia</b>   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>5268 Cedar Lane, Apt. 184</b>   |  |  |   |  |   | 10f. Zip Code<br><b>21044</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Vietnam</b><br>If Yes, Give Year or Dates: <b>ERA</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+)  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Operations Manager</b> |   |  |   | 16b. Kind of Business/Industry<br><b>Trading</b>                        |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Unknown Botticelli</b>   |  |  |   |  |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Julie Unknown</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Jamal Botticelli Son</b>  |  |  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5268 Cedar Lane, Apt. 184 Columbia, Maryland 21044</b> |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                       |   | Date<br><b>04/22/99</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |   |  |   | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>                                     |   |   |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |   |  |   |  |   |   |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Brain death</b><br>Due to (or as a consequence of):   |  |  |   |  |   |  |   |   |  | 24 hr.   |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. <b>Massive cerebral edema</b><br>Due to (or as a consequence of):   |  |  |   |  |   |  |   |   |  | 24 hr.   |
| c. <b>Anoxic encephalopathy</b><br>Due to (or as a consequence of):  |  |  |   |  |   |  |   |   |  | 1 wk   |
| d. <b>Pulmonary edema</b>  |  |  |   |  |   |  |   |   |  | 1 wks  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>1st Hypertension, Cardiomegaly</b><br><b>2nd Hypertension, Liver failure</b>  |  |  |   |  |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  | 29b. Signature and title of certifier<br><b>Anthony P. Zavadil III MD</b>   |  |   | 29c. License number<br><b>D34149</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Apr. 21, 1999</b>             |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anthony Zavadil 10810 Hickory Ridge Rd. Columbia, Md 21044</b>  |  |  |   |  |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 28 1999</b>  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16419

|   |  |   |  |  |   |  |   |  |
|---|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE BOPST</b>                                    |   |  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>08</b> Year <b>1999</b> |  | 3. Time of Death<br><b>6:00 AM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>         |  | 4c. County of Death<br><b>Baltimore</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-18-7245</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 12, 1926</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>                                     |  | 10c. City, Town or Location<br><b>Randallstown</b>          |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>10234 Liberty Road</b>   |  | 10f. Zip Code<br><b>21133</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bus Contractor</b>  |  | 16b. Kind of Business/Industry<br><b>Transportation</b>  |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Nilton S. Bopst</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Flynn</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Carolyn S. Bopst (Wife)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10234 Liberty Road Randallstown, MD 21133</b>  |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Family Cemetery</b>   |  | Date<br><b>5/12/99</b>   |   | 20c. Location - City or Town, State<br><b>Randallstown, MD</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian A. Haight</b>   |  |   |  | 22. Name and Address of Facility<br><b>HAIGHT FUNERAL HOME &amp; CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400</b>  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ENDSTAGE RENAL FAILURE.</b><br>Due to (or as a consequence of):<br><b>GLOMERULO NEPHRITIS</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>CONGESTIVE HEART FAILURE</b><br><b>CARDIOMYOPATHY.</b><br><b>ADENOSARCOMA OF PROSTATE.</b> |  |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b><br><b>CARDIOMYOPATHY.</b><br><b>ADENOSARCOMA OF PROSTATE.</b>   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Hannah HOUSE PHYSICIAN</b>  |  | 29c. License number<br><b>D42723.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>5/8/99</b>   |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AVVERA HALL M HARISH. 3745 FOXFORD STREAM RD BALTIMORE MD 21236.</b>   |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 10 1999</b>   |  | 32. Registrar's Signature<br><b>Benita S. Sparks</b>  |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 16420**  
**Certificate of Death**

Reg. No.

|   |   |                                    |  |   |  |   |  |  |   |
|---|---|------------------------------------|--|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Sheila Marie Beattie</b>                           |                                    |  |   |  | 2. Date of Death<br>Month Day Year<br><b>May 2nd 1999</b> |  | 3. Time of Death<br><b>5:15 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1015 Norman Dr. Apt. T-2</b> |                                    |  |   |  | 4b. City, Town, or Location of Death<br><b>Annapolis</b>  |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>585-32-5103</b>   |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth<br>(Month, Day, Year)<br><b>Dec. 14, 1930</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>England</b>  |
|   | Usual Residence of Decedent   |                                    |  |   |  |   |  |  |   |
| 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Anne Arundel</b> |  | 10c. City, Town or Location<br><b>Annapolis</b>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>1015 Norman Drive</b>  |   |                                    |  | 10f. Zip Code<br><b>21403</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>               |  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |   | 16b. Kind of Business/Industry<br><b>Own home</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Michael Morgan</b>  |   |                                    |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jane Anne Lowe</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward Beattie / husband</b>   |   |                                    |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1015 Norman Dr. Apt. T-2 Annapolis, Md. 21403</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Crematory</b>   |   | Date<br><b>5-3-99</b>  |   | 20c. Location - City or Town, State<br><b>Brentwood, Md.</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Beverly C. Baker</i>  |   |                                    |  |   | 22. Name and Address of Facility<br><b>John M. Taylor Funeral Home, Inc.<br/>147 Duke of Gloucester St. Annapolis, Md. 21401</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Cardiac arrest</b><br>Due to (or as a consequence of):<br><br>b. <b>CHF - congestive heart failure</b><br>Due to (or as a consequence of):<br><br>c. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><br>d. <b>Hypercholesterolemia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                                    |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><br><b>&gt;10yrs</b><br><br><b>&gt;10yrs.</b><br><br><b>7 to 10yr</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Renal Insufficiency</b><br><b>Peripheral Vascular Disease</b><br><b>Hypothyroidism</b>   |   |                                    |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |                                    | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                                    |  |   |  |   |  |  |   |
| 29b. Signature and title of certifier<br><b>Ritamarie Moscola M.D.</b>  |   |                                    |  |   | 29c. License number<br><b>D-35248</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 3, 1999</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RITAMARIE MOSCOLA MD Primary Care Clinic USNA Annapolis, MD 21402</b>  |   |                                    |  |   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>   |   |                                    | 32. Registrar's Signature<br><i>B. Sparks</i>  |   |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



POSTAGE WILL BE PAID BY ADDRESSEE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |  |   |  |
|--|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hariett M. Barnes</b>                                     |   |  |  | 2. Date of Death<br>Month: <b>05</b> Day: <b>01</b> Year: <b>99</b> |  | 3. Time of Death<br><b>6:10 PM</b>                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>             |  | 4c. County of Death<br><b>Prince George's</b>         |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579 68 3387</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.                    |  | 8. Date of Birth (Month, Day, Year)<br><b>5/27/29</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Canada</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George's</b>                               |  | 10c. City, Town or Location<br><b>New Carrollton</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>7505 Riverdale Road</b>  |  | 10f. Zip Code<br><b>20784</b>  |   | 10g. Citizen of What Country?<br><b>Canada</b>   |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Auditor</b>   |  | 16b. Kind of Business/Industry<br><b>Banking</b>   |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Thomas W. Barnes</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Ada Slinger</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William H. Barnes (brother)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2574 Tanglewood Dr., Wooster, Ohio 44691</b>   |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>5/4/99</b>  |   | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Melanie Wilkins</b>  |  |   |  | 22. Name and Address of Facility<br><b>Advent Funeral &amp; Cremation Services<br/>Annapolis, Maryland 21401</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Chronic obstructive pulmonary disease with exacerbation</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>20+ yrs</b>  |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b><br><b>Hypertensive cardiovascular disease</b><br><b>Chronic renal failure</b>   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D13574</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/11/99</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>F. Sotoudeh MD 7525 Greenway Center Drive, Greenbelt, MD 70770</b>  |  |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

THE UNITED STATES OF AMERICA  
DO NOT  
WARRANT  
THE  
RELIABILITY  
OF  
THE  
INFORMATION  
CONTAINED  
HEREIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16422

|  |  |  |   |   |  |   |  |  |
|--|--|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MARY J. BROWN</b>   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 27 1999</b>   |   | 3. Time of Death<br><b>11:10 A.M.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>North Crundel Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-52-9824</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>52</b>   | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 16 1947</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>  |  |
|  | Usual Residence of Decedent  |  |   |   |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>  |   | 10c. City, Town or Location<br><b>ANNAPOLIS</b>  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>34 PAROLE STREET</b>  |  |   |   | 10f. Zip Code<br><b>21401</b>  |   | 10g. Citizen of What Country?<br><b>US</b>   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                            |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collegia (1-4 or 5+)<br><b>11th 0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CUSTODIAN</b>   |   | 16b. Kind of Business/Industry<br><b>ANNE ARUNDEL CO. PUBLIC SCHOOL</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JOHN RAGSDALE</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BEATRICE LOGAN</b>   |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MICHELL SAVOY (DAUGHTER)</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1252 CREEK DRIVE ANNAPOLIS, MD. 21403</b>  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ANNAPOLIS MEM. GARDENS</b>   |   | 20c. Location - City or Town, State<br><b>5/1/99 ANNAPOLIS, MD.</b>  |   | 20d. Date  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Larry S. Reese</i>   |  |   |   | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>HN - AIDS</b></p> <p>b. <b>Kaposi's Sarcoma</b></p> <p>c. <b>Encephalitis</b></p> <p>d. <b>Malnutrition</b></p> </div> <div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> </div> |  |   |   |  |   |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |   |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |   |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |   |  |   |  |  |
| State Registrar  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |   |  |   |  |  |
|  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |
|  | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>3 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>Asim MD</i>  |  |  |   | 29c. License number<br><b>D43977</b>          |  | 29d. Date signed (Month, Day, Year)<br><b>April 27 1999</b> |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dyorn Breenji. 301 Hospital Drive Glen Burnie. MD. 21061.</b>   |  |  |   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>  |  |  |   | 32. Registrar's Signature<br><i>P. Sparks</i> |  |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |   |   |   |
|---|--|---|---|--|--|---|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT T. BLACKWELL, SR.</b>                      |   |   |  | 2. Date of Death<br>Month Day Year<br><b>MAY 3, 1999</b>   |   | 3. Time of Death<br><b>12:35 pm</b>     |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CHARLESTOWN CARE CENTER</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>CATONSVILLE</b> |   | 4c. County of Death<br><b>BALTIMORE</b> |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-07-0010</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>101</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                             | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 6, 1897</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b> |
|   | Usual Residence of Decedent  |   |   |  |  |   |   |   |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>BALTIMORE</b>   |   | 10c. City, Town or Location<br><b>CATONSVILLE</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
| 10e. Street and Number<br><b>311 CHAPEL COURT</b>   |  |   |   | 10f. Zip Code<br><b>21228</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>+4</b>   |  |   |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CHEMIST</b>   |  | 16b. Kind of Business/Industry<br><b>CHEMICAL COMPANY</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>ALBERT RICHARD BLACKWELL</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARGARET M. TURNER</b>   |  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ALBERT T. BLACKWELL, JR. (SON)</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16205 MARLBORO PIKE, UPPER MARLBORO, MD. 20772</b>                                       |  |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK</b>  |   | Date<br><b>5/6/99</b>  |  | 20c. Location - City or Town, State<br><b>ELKRIDGE, MD.</b>   |   |   |
| 21. Signature of Funeral Service Licensee<br><i>Michael C. Gaffney</i>  |  |   |   | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>   |  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Aspiration pneumonia</b><br>Due to (or as a consequence of):<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   |  |  |   |   | Approximate Interval Between Onset and Death<br><b>1</b>          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
|   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred  |  |   |   |   |
|   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>Myla M. Carpenter</i>   |   |  |  |   |   |   |
|   |  | 29c. License number<br><b>D30989</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>May 04 1999</b>  |  |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Myla M. Carpenter MD 711 Maiden Choice Ln</b>  |  |   |   |  |  |   |   |   |
| 31. Date Died (Month, Day, Year)<br><b>MAY 05 1999</b>  |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |  |   |   |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16424

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Anna Bryant

2. Date of Death

Month Day Year  
5-2-99

3. Time of Death

10 A.M.

4a. Facility Name (If not institution, give street and number)

Future Care Review

4b. City, Town, or Location of Death

Clinton

4c. County of Death

P. G. County

5. Social Security Number

577-32-3882

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 16, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9106 Pineview Lane

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Presser

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

William Allen

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Barnes

19a. Informant's Name/Relationship (Type, Print)

Phyllis Brown - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1440 - 7th St., Glenarden, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

5/6/99

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home  
4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction  
Due to (or as a consequence of):

Sudden

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic cardiovascular disease  
Due to (or as a consequence of):

years

c. disease  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

old CHF with Lt. hypertrophy.  
Senile dementia.  
Decubitus ulcers.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

HYO K. Lee MD

29c. License number

D15595

29d. Date signed (Month, Day, Year)

05/02/1999

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

HYO K. LEE MD 11610 LOCUST GLEN DR MITCHELLVILLE, MD 20721

31. Date filed (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 16425**  
**Certificate of Death**

Reg. No.

|  |  |                            |   |  |  |   |  |   |  |
|--|--|----------------------------|---|--|--|---|--|---|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Ellowyese D. Brokenborough</b>                          |                            |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APR 29 1999</b>    |  | 3. Time of Death<br><b>4:35am</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington Adventist Hospital</b> |                            |   |  |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |  | 4c. County of Death<br><b>Montgomery</b>                                |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>579-22-4421</b>  |                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>11/18/18</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b> |
|  | Usual Residence of Decedent  |                            |   |  |  |   |  |   |  |
| 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>P.G.</b> |   | 10c. City, Town or Location<br><b>Capitol Hgts.</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>1307 Early Oaks Lane</b>  |  |                            |   | 10f. Zip Code<br><b>20743</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>              |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)  |  |                            |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sorter</b> |  |   | 16b. Kind of Business/Industry<br><b>U.S. Post Office</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Willie Drake</b>   |  |                            |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lee Ethel Gray</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alfred T. Brokenborough/Husband</b>   |  |                            |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as # 10 above</b>   |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washington Nat'l. Cem. 5/7/99</b>  |  |  | 20c. Location - City or Town, State<br><b>Suitland, Md.</b> |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Gary W. Pratt</b>  |  |                            |   |  | 22. Name and Address of Facility<br><b>H.S. Washington &amp; Sons Co., Inc.<br/>4925 Burroughs Ave., N.E., Wash., D.C. 20019</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Respiratory Failure</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Sepsis</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Diabetes Mellitus</b><br/>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>1 day</b></p> <p><b>3 days</b></p> <p><b>&gt; years</b></p> </div> </div> |  |                            |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Accident</b>  |  |                            |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |  |                            |   |  |  |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  |                            |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |                            | 28e. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred                              |
|  |  |                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                            | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  |  | 29c. License number<br><b>D19609</b>                        |  | 29d. Date signed (Month, Day, Year)<br><b>04-29-99</b>                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RAMAN R. TULI, MD 3503 PERRY STREET MOUNT RAINIER, MD 20712</b>   |  |                            |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 03 1999</b>  |  |                            | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16426

|                                     |   |   |  |  |  |  |   |  |  |
|-------------------------------------|---|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy E. Baker</b>   |   |  |  | 2. Date of Death<br>Month: <b>April</b> Day: <b>30</b> Year: <b>1999</b>   |  | 3. Time of Death<br><b>3:30PM</b>   |  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>8804 McHenry Lane</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>  |  | 4c. County of Death<br><b>Prince George's</b>   |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>212-20-0930</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 18, 1917</b>   |  |  |
|                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10. Usual Residence of Decedent<br>10a. State: <b>Maryland</b> 10b. County: <b>Prince George's</b> 10c. City, Town or Location: <b>Lanham</b> 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:  |  |  |
| To Be Completed by Funeral Director | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>9th</b> Collage (1-4or 5+): <b>Collage</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse Assistant</b>   |  |  |
|                                     | 16b. Kind of Business/Industry<br><b>Private</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Lloyd Baker</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ethel Watson</b>   |  | 19. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8804 McHenry Lane, Lanham, MD 20706</b>  |  |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>   |  | 21. Signature of Funeral Service Licensee<br><b>John T. Stewart III</b>   |  |  |
|                                     | 22. Name and Address of Facility<br><b>Stewart Funeral Home</b>   |   | 23a. Pertinent diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>acute leukemia</b>                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| Physician<br>/Medical<br>Examiner   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify):  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |  |
|                                     | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>8926 Woodyard Rd. Suite 201</b>   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and Title of certifier<br><b>D.J. HALDAK MD</b>  |  |  |
|                                     | 29c. License number<br><b>D-17605</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/3/99</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CLINTON MD</b>  |  | 31. Data filed (Month, Day, Year)<br><b>MAY 03 1999</b>   |  |  |
| State Registrar                     |   | 32. Registrar's Signature<br><b>B. Spotts</b> |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 16427**  
**Certificate of Death**

Reg. No.

|  |   |                                       |   |   |   |  |  |  |  |  |  |
|--|---|---------------------------------------|---|---|---|--|--|--|--|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Charles H. Bird</b>                                    |                                       |   |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>4</b> Year <b>1999</b> |  | 3. Time of Death<br><b>9:45 A.M.</b>   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Charlotte Hall Veterans Home</b> |                                       |   |   |   | 4b. City, Town, or Location of Death<br><b>Charlotte Hall</b>      |  | 4c. County of Death<br><b>St. Mary's</b>   |  |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>463-10-4380</b>   |                                       | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 1, 1917</b>                           |  | 9. Birthplace (State or Foreign Country)<br><b>Texas</b> |  |  |
|  | Usual Residence of Decedent   |                                       |   |   |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b> |   | 10c. City, Town or Location<br><b>Fort Washington</b> |   |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>702 Loch Ness Circle</b>  |   |                                       |   |   | 10f. Zip Code<br><b>20744</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1941-64</b>  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |  |  |  |
|  |   |                                       | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Military</b>  |  |  | 16b. Kind of Business/Industry<br><b>U.S. Air Force</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles H. Bird</b>  |   |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Allen</b>   |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia E. Bird/Wife</b>   |   |                                       |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>702 Loch Ness Circle, Ft. Washington, MD 20744</b>  |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery 5/13/99 Arlington, VA</b>  |   |   | Date   |  | 20c. Location - City or Town, State  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                                       |   |   | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home, P.A.<br/>6160 Oxon Hill Rd. Oxon Hill, MD 20745</b>  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  |   |                                       |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>e. <b>FAILURE TO THRIVE</b><br>Due to (or as a consequence of):<br>b. <b>DYSPHAGIA</b><br>Due to (or as a consequence of):<br>c. <b>SUPRANUCLEAR PALSY</b><br>Due to (or as a consequence of):<br>d.  |   |                                       |   |   |   |  |  |  |  | 1 Month  |  |
|  |   |                                       |   |   |   |  |  |  |  | MONTHS   |  |
|  |   |                                       |   |   |   |  |  |  |  | YRS  |  |
|  |   |                                       |   |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>  |   |                                       |   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |   |                                       |   |   |   |  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |   |                                       |   |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                                       | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                        |  |  |
|  |   |                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                       |   |   |   |  |  |  |  | 29b. Signature and title of certifier<br>   |  |
|  |   |                                       |   |   | 29c. License number<br><b>D-44436</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>May 04 1999</b>                            |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ASHVINKUMAR J PATEL 6 INDUSTRIAL DR, WASHINGTON MD 20601</b>  |   |                                       |   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 05 1999</b>  |   |                                       | 32. Registrar's Signature<br>  |   |   |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician  
/Medical  
Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

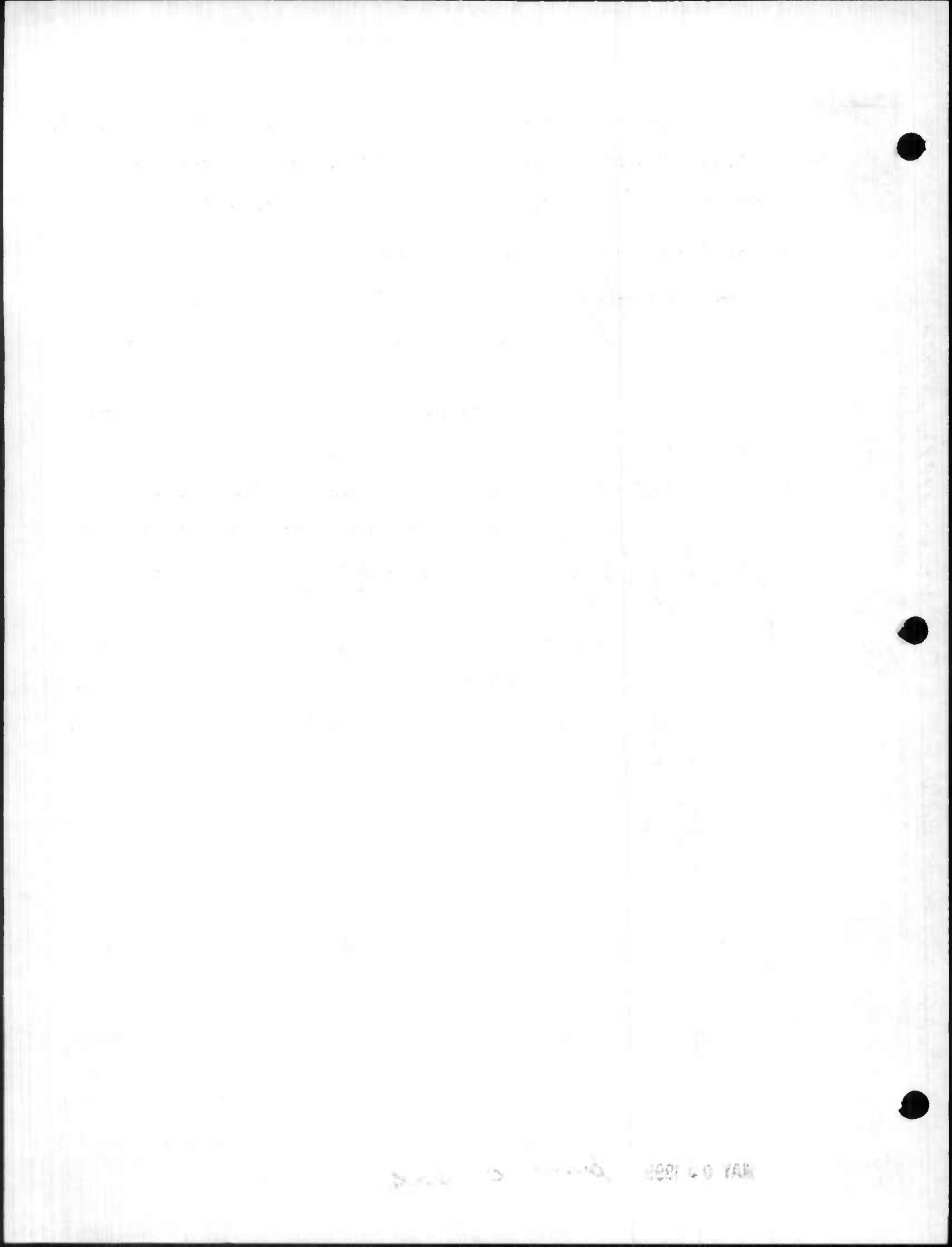
**State  
Registrar**

MAY 04, 1999 9:45AM

CHARLES H. BIRD

(10)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amend item # 5.&amp; 8.Per FH PGC 5-10-99 cr

99 16428

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES S. BRANTLEY

2. Date of Death

Month Day Year  
MAY 3, 1999

3. Time of Death

3:40PM

4a. Facility Name (If not institution, give street and number)

CARRIAGE HILL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

~~519-42-3164~~  
~~577-09-9341~~

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 11, 1911

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3279 Van Hazen St. NW

10f. Zip Code

20015

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supply Officer

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Vernon T. Brantley

18. Mother's Name (First, Middle, Maiden Surname)

Frances Ceese

19a. Informant's Name/Relationship (Type, Print)

Iris Grassel-Executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3279 Van Hazen St. NW, Washington, DC 20015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

5/5/99

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons INC., 5130 Wisconsin Ave.  
NW, Washington, DC 2001623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Cerebral Vascular Accident

Approximate  
Interval Between  
Onset and Death

7 days

Due to (or as a consequence of):

Hypertension

years

Due to (or as a consequence of):

Atherosclerotic Cardiovascular Disease

years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Status Post Coronary Bypass Graft 2 years plus

Gait imbalance

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D35579

29d. Date signed (Month, Day, Year)

May 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller MD., 6844 Tulip Hill Terrace., Bethesda, MD 20816

31. Date filed (Month, Day, Year)

MAY 06 1999

32. Registrar's Signature

Susan J. Miller

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

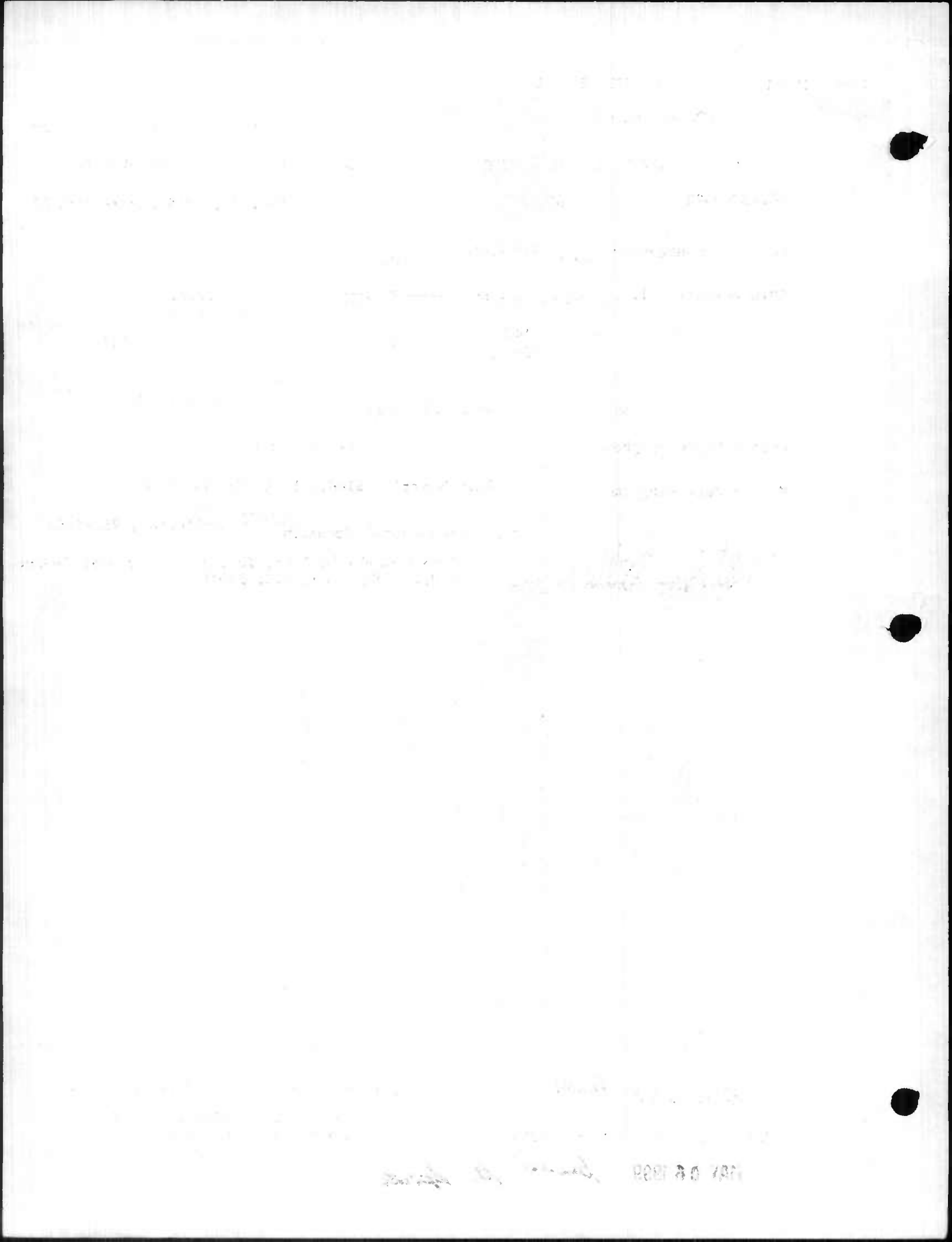
State of Maryland / Department of Health and Mental Hygiene

Amended Item#10a,b,c,e,f perFH G772 6/28/99 EW

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |  |  |  |   |  |  |  |
|---|---|--|--|--|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>ROBERT HAROLD BINGHAM   |  |  |  |  |  | 2. Date of Death<br>Month Day Year<br>MAY 3 1999                  |  | 3. Time of Death<br>1:08 PM  |  |   |  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>NATIONAL NAVAL MEDICAL CENTER   |  |  |  |  |  | 4b. City, Town, or Location of Death<br>BETHESDA                  |  | 4c. County of Death<br>MONTGOMERY  |  |   |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>002-30-3028  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>80 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 26, 1919              |  | 9. Birthplace (State or Foreign Country)<br>Washington, DC   |  |   |  |  |  |
|   | Usual Residence of Decedent   |  |  |  |  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD NH   |  | 10b. County<br>Montgomery Bristol  |  | 10c. City, Town or Location<br>Bethesda Bristol  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
|   | 10e. Street and Number<br>8010 Whittier Blvd. 50 Browns Beach RD  |  |  |  | 10f. Zip Code<br>20817 03222   |  |   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII<br>If Yes, Give Year or Dates: Korea |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4+ Collega (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Col. U.S. Army                                  |  |  |  | 16b. Kind of Business/Industry<br>U.S. Military                   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Harold Clyde Bingham   |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Lucille Forest |  |  |  |   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Martha Jane Bingham   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8010 Whittier Blvd., Bethesda, MD 20817   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cemetery  |  |   |  | 20c. Location - City or Town, State<br>Arlington, Virginia   |  |   |  |  |  |
|   | 21. Signature of Funeral Service Licensee   |  |  |  | 22. Name and Address of Facility<br>Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W., Washington, D.C. 20016  |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>PULMONARY FIBROSIS<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  | 28a. Date of Injury (Month, Day, Year)   |  |   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
|   | 28d. Describe how Injury occurred   |  |  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  | 29b. Signature and title of certifier<br>Carla D. TANNA  |  | 29c. License number<br>0101-056626 (VA)   |  | 29d. Date signed (Month, Day, Year)<br>04 MAY 99 |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CAROLA A. TANNA, LT, MC, USNR   |  |  |  |  |  |   |  | NATIONAL NAVAL MEDICAL CENTER<br>BETHESDA MD 20809-5600  |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br>MAY 06 1999  |  |  |  | 32. Registrar's Signature<br>B. B. B.  |  |   |  |  |  |   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16430

|  |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
|--|---|----------------------------------|--|---|--|--|--|--|---|----|-------------------|--|----|--|----|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James Bryant</b>   |                                  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>5</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>2:45 A.M.</b>   |  |   |    |                   |  |    |  |    |  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care Health Services of Bethesda</b> |                                  |  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |   |    |                   |  |    |  |    |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-38-0289</b>   |                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>1921 December 14,</b>                                |  |   |    |                   |  |    |  |    |  |    |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| Usual Residence of Decedent  |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 10a. State<br><b>District of Columbia</b>  |   | 10b. County<br><b>Washington</b> |  | 10c. City, Town or Location<br><b>Washington</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |                   |  |    |  |    |  |    |  |
| 10e. Street and Number<br><b>4625 - 8th Street, N. W.</b>  |   |                                  |  | 10f. Zip Code<br><b>20011</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                        |  |  |   |    |                   |  |    |  |    |  |    |  |
| 11. Marital Status <b>Separated</b><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:          |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |   |    |                   |  |    |  |    |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th grade</b> College (1-4or 5+)  |   |                                  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Apartment Buildings</b>                 |  |  |   |    |                   |  |    |  |    |  |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Bryant</b>  |   |                                  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beatrice Honesty</b>  |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Edith J. Bryant (Niece)</b>   |   |                                  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3 Carver Road, Cabin John, Maryland 20818</b>   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Forest Hills Memorial Gardens</b>  |  | 20c. Location - City or Town, State<br><b>Clinton, Maryland</b>              |  |  |   |    |                   |  |    |  |    |  |    |  |
| 21. Signature of Funeral Service Licensee<br><i>Timothy R. Adkins</i>  |   |                                  |  | 22. Name and Address of Facility<br><b>Robert G. Mason Funeral Home, Inc.<br/>1661 Good Hope Road, S.E.; Washington, D.C. 20020</b>   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Tracheitis</b></td> <td rowspan="4">           Due to (or as a consequence of):<br/> <b>Chronic Obstructive Pulmonary Disease</b><br/><br/> <b>Status Post Colostomy</b><br/><br/> <b>Status Post Gastrostomy</b> </td> </tr> <tr> <td>b.</td> <td></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |                                  |  |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Tracheitis</b> | Due to (or as a consequence of):<br><b>Chronic Obstructive Pulmonary Disease</b><br><br><b>Status Post Colostomy</b><br><br><b>Status Post Gastrostomy</b> | b. |  | c. |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.  | <b>Tracheitis</b>                | Due to (or as a consequence of):<br><b>Chronic Obstructive Pulmonary Disease</b><br><br><b>Status Post Colostomy</b><br><br><b>Status Post Gastrostomy</b> |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
|  | b.  |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
|  | c.  |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
|  | d.  |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                                  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |    |                   |  |    |  |    |  |    |  |
|  |   |                                  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |    |                   |  |    |  |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                                  |  | 29b. Signature and title of certifier<br><i>Kirti Vohra M.D.</i>  |  | 29c. License number<br><b>D 20274</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 5, 1999</b>                        |   |    |                   |  |    |  |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kirti Vohra, M.D.; 1299 Lamberton Street, Silver Spring, Maryland 20902</b>   |   |                                  |  |   |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>  |   |                                  |  | 32. Registrar's Signature<br><i>B. Spate</i>  |  |  |  |  |   |    |                   |  |    |  |    |  |    |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16431

|  |  |   |  |  |   |   |   |   |  |
|--|--|---|--|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EMMA LOU CRAIG</b>                                      |   |  |  | 2. Date of Death<br>Month <b>4</b> Day <b>28</b> Year <b>99</b> |   | 3. Time of Death<br><b>0350</b>                                 |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>TAKOMA PARK</b>      |   | 4c. County of Death<br><b>MONT</b>                              |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>250-36-7322</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                |   | 8. Date of Birth<br>Month <b>5</b> Day <b>26</b> Year <b>25</b> |   |  |
|  | 9. Birthplace (State or Foreign)<br><b>LAURENS, SC</b>   |   | 10a. State<br><b>DC</b>  |  | 10b. County<br><b>N/A</b>                                       |   | 10c. City, Town or Location<br><b>WASHINGTON</b>                |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3515 26TH STREET NE</b>   |   | 10f. Zip Code<br><b>20018</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b>  |  | College (1-4 or 5+) <b>NONE</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALES STORE WORKER</b>   |   | 16b. Kind of Business/Industry<br><b>SALES STORE</b>  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIE JAMES BOYD</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ETHEL IRBY</b>   |   |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HARRIET A. KEELS (DAUGHTER)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6610 LAMONT DRIVE, HYATTSVILLE, MD 20784</b>   |   |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington Nat. Cem.</b>  |  | Date<br><b>5/6/99</b>  |   | 20c. Location - City or Town, State<br><b>Arlington, Va.</b>                                |   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Juan Smiles</i>  |  |   |  | 22. Name and Address of Facility<br><b>JOHN T RHINES CO., INC.<br/>3030 12TH ST NE, DC 20017</b>   |   |   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | a. <i>Gastrointestinal Bleeding</i><br>Due to (or as a consequence of):<br>b. <i>Pulmonary Fibrosis</i><br>Due to (or as a consequence of):<br>c. <i>Congestive heart failure</i><br>Due to (or as a consequence of):<br>d. |  | Approximate Interval Between Onset and Death<br><br><i>1 day</i><br><i>&gt; years</i><br><i>&gt; years</i>   |   |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic renal failure</i><br><i>Hypertension</i>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |   |   |  |
|  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                  |   |   |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D19609</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>4-28-99</b>                                       |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>R-TULI. 3503 PERRY STREET, MOUNT RAINIER, MD 20712</b>  |  |   |  |  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |   |   |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified in advance.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



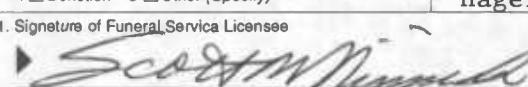
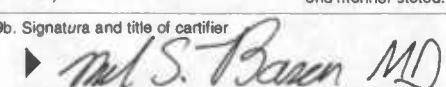
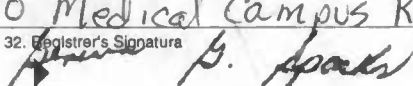
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16432

|   |  |  |   |   |  |                                |   |  |
|---|--|--|---|---|--|--------------------------------|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Janice Elizabeth COFFEEN</b>  |  |   |   | 2. Date of Death<br>Month <b>May</b> Day <b>7</b> Year <b>1999</b>   |                                | 3. Time of Death<br><b>0053</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |                                | 4c. County of Death<br><b>Washington</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>003-18-6894</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 19 1929</b>  | 9. Birthplace (State or Foreign Country)<br><b>New Hampshire</b> |
|   | Usual Residence of Decedent  |  |   |   |  |                                |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>  |   | 10c. City, Town or Location<br><b>Hagerstown</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 10e. Street and Number<br><b>11534 Green Valley Drive</b>  |  |   |   | 10f. Zip Code<br><b>21740</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Executive Secretary</b>           |   | 16b. Kind of Business/Industry<br><b>Mental Health Center</b>  |                                |   |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Albert Lantz</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lena Dresser</b>   |                                |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Coffeen - Husband</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11534 Green Valley Drive Hagerstown, Md. 21740</b>                                       |                                |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>   |   | Date<br><b>5/7/99</b>  |                                | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Md. 21740</b>  |                                |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASYSTOLE</b><br>Due to (or as a consequence of):<br><b>b. OVERWHELMING METABOLIC ACIDOSIS</b><br>Due to (or as a consequence of):<br><b>c. GRAM NEGATIVE SEPSIS</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |  |                                | Approximate Interval Between Onset and Death  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MYOCARDIAL ISCHEMIA</b><br><b>CARDIOMYOPATHY</b>  |  |   |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| State Registrar   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |  |                                | 29b. Signature and title of certifier<br>  |  |
|   | 29c. License number<br><b>D53071</b>   |  |   |   |  |                                | 29d. Date signed (Month, Day, Year)<br><b>05/07/99</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. BARAN 11110 Medical Campus Rd. Hagerstown Maryland</b> |  |  |   |   |  |                                |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>   |  |  |   | 32. Registrar's Signature<br> |  |                                |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16433

|  |  |   |  |  |  |   |  |   |
|--|--|---|--|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH LOUISE CHAFIN</b>                                 |   |  |  | 2. Date of Death<br>Month <b>5</b> Day <b>7</b> Year <b>99</b> |   | 3. Time of Death<br><b>1432</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Peninsula Regional Medical Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Salisbury</b>       |   | 4c. County of Death<br><b>Wicomico</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-38-9429</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.   | If Under 1 Year<br>Months Days                                 | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>7/28/39</b>  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                 |
|  | Usual Residence of Decedent  |   |  |  |  |   |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Berlin</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>#39 Harlan Trace</b>  |  |   |  | 10f. Zip Code<br><b>21811</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> Collega (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Finance Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Credit Corp.</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Lewis Hamlett</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Mary Herrlein</b>   |  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James A. Chafin/ Husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>#39 Harlan Trace Berlin, MD 21811</b>  |  |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garden of the Pines Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Berlin, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Burbage Funeral Home<br/>108 William St. Berlin, MD 21811</b>   |  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>ASCAD with left main coronary stenosis</b><br>Due to (or as a consequence of):<br>b. <b>Acute myocardial infarction</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death<br><br><b>1 yr.</b><br><b>9 days</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>Carcinoma of lung 2 yrs ago</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>02038</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/10/99</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael P. Buchness 201 Pine Bluff Rd. Salisbury, Md 21801</b>  |  |   |  |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 12 1999</b>  |  | 32. Registrar's Signature<br>   |  |  |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





TINA ANNE CHASE  
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16434

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>TINA ANNE CHASE</b>  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>11</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>7:24 P</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>7306 DONNELL RD.</b>   |  |   | 4b. City, Town, or Location of Death<br><b>FORESTVILLE</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>               |
| 5. Social Security Number<br><b>214-04-0380</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>15</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 26 1983</b> |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Forestville</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |
| 10e. Street and Number<br><b>7306 Donnell Place C-7</b>   |  |   | 10f. Zip Code<br><b>20747</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                |
| 11. Mental Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>   |  | 16b. Kind of Business/Industry<br><b>Laurel High School Laurel, MD</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elandus Carver</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catalina Chase</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Catalina Chase (Mother)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7306 Donnell Place C-7 Forestville, MD 20747</b> |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 5-13-99</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>   |  |
| 21. Signature of Funeral Service Licensee<br><b>John H. Carver</b> M00173   |  | 22. Name and Address of Facility<br><b>J.H. Eberwein Mortuary<br/>4433 White Pls La White Pls., MD 20695</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Contact gunshot wound of the head</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>5-11-99</b>  |  | 28b. Time of Injury<br><b>0723 M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Subject shot self</b>   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>7306 Donnell Road Prince Georges County, Maryland</b>  |  |  |  |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Stephen S. Radentz, MD</b>  |  | 29c. License number<br><b>O.C.M.E</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 12, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 13 1999</b>   |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16435

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Florence L. Collison</i>  |  |   |  | 2. Date of Death<br>Month <i>4</i> Day <i>16</i> Year <i>99</i>  |  | 3. Time of Death<br><i>10:25 p</i>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Future Care - Cherrywood</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>Riesterstown</i>  |  | 4c. County of Death<br><i>Baltimore</i>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>220-09-1222</i>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>87</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>June 24, 1911</i>                                 |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>Stevensville, MD</i>  |  | 10a. State<br><i>MD</i>   |  | 10b. County<br><i>Carroll</i>  |  | 10c. City, Town or Location<br><i>Upperco</i>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><i>15119 East View Drive</i>  |  | 10f. Zip Code<br><i>21155</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>2+</i> College (1-4 or 5+) <i>2+</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Nurse</i>                         |  | 16b. Kind of Business/Industry<br><i>Medicine</i>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Linwood E. Lane</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Eugenia E. Radcliffe</i>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Henry H. Davis - Son</i>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>15119 East View Drive, Upperco, MD 21155</i>   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Stevensville Cemetery</i>  |  | 20c. Location - City or Town, State<br><i>Stevensville, MD</i>   |  | 20d. Date<br><i>April 20, 1999</i>  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Chad N. Hefner</i>   |  |   |  | 22. Name and Address of Facility<br><i>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A.<br/>106 Shamrock Road, Chester, MD 21619</i>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Alzheimer's Dementia</i>   |  |   |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br><i>Robert L. Mott, MD</i>   |  |   |  | 29c. License number<br><i>032882</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>4/19/99</i>                                       |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Robert L. Mott 114 Business Center Drive Riesterstown, MD 21135</i>   |  |   |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><i>APR 22 1999</i>  |  |   |  | 32. Registrar's Signature<br><i>Debra B. Sparks</i>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

16436

|  |  |  |   |                               |  |  |  |  |  |  |
|--|--|--|---|-------------------------------|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Nicholas R. Chirumbole   |  |   |                               | 2. Date of Death<br>Month Day Year<br>April 15, 1999   |  |  |  | 3. Time of Death<br>5:47 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center  |  |   |                               | 4b. City, Town, or Location of Death<br>Annapolis  |  |  |  | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>194-09-8202   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>82 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 14, 1916                                 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|  | Usual Residence of Decedent  |  |   |                               |  |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   |  | 10b. County<br>Anne Arundel   |                               | 10c. City, Town or Location<br>Annapolis (Manresa Senior Quarters)   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br>85 Manresa Road, Apt. 212  |  |   |                               | 10f. Zip Code<br>21401   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Customer Service Manager                 |                               |  |  | 16b. Kind of Business/Industry<br>Defense  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Peter Chirumbole  |  |   |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Angela DiCello  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>N. Robert Chirumbole   |  |   |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>849 DeFranceaux Harbor, Pasadena, MD 21122  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Peter's Cemetery  |                               | 20c. Date<br>April 19, 1999  |  | 20d. Location - City or Town, State<br>Queenstown, MD                                |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Ames Michewitz</i>   |  |   |                               | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>106 Shamrock Road, Chester, MD 21619  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Chronic obs. pulm. disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                               |  |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |                               |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                               |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |                               |  |  |  |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |   |                               |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                               | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28t. Location (Street and Number or Rural Route Number, City or Town, State)  |                               |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |                               |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Wm. A. DABBS</i>   |  |  |   | 29c. License number<br>D24768 |  | 29d. Date signed (Month, Day, Year)<br>4/16/99 |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DABBS, Wm. A. 177 DEFENSE HWY ANNAPOLIS, MD 21401  |  |  |   |                               |  |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>APR 19 1999   |  |   |                               | 32. Registrar's Signature<br><i>B. Sparks</i>  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16437

|  |  |  |   |   |  |   |  |   |
|--|--|--|---|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Dorothy W. Crouch  |  |   |   | 2. Date of Death<br>Month Day Year<br>April 10, 1999   |   | 3. Time of Death<br>4:00 PM  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>The Skyler House   |  |   |   | 4b. City, Town, or Location of Death<br>Church Hill  |   | 4c. County of Death<br>Queen Anne's  |   |
| Funeral<br>Director  | 5. Social Security Number<br>218-20-3792   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>89 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth (Month, Day, Year)<br>Dec. 21, 1909   |   |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |   |  |   |  |   |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |   |   |  |   |  |   |
|  | 10a. State<br>MD   |  | 10b. County<br>Queen Anne's   |   | 10c. City, Town or Location<br>Church Hill   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|  | 10e. Street and Number<br>222 Walnut Street/P.O. Box 93  |  |   |   | 10f. Zip Code<br>21623   |   | 10g. Citizen of What Country?<br>U.S.A.  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>2   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher  |  | 16b. Kind of Business/Industry<br>Education |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>James F. White  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lena Hopkins  |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Beverly Young - Daughter   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1014 Spaniard Neck Road, Centreville, MD 21617  |   |  |   |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Stevensville Cemetery   |   | Date<br>April 14, 1999   |   | 20c. Location - City or Town, State<br>Stevensville, MD  |   |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>106 Shamrock Road, Chester, MD 21619  |   |  |   |
|  | Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No              |  |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |
|  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |   |  |   |
|  | 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br>D 357105  |   | 29d. Date signed (Month, Day, Year)<br>4/13/99   |   |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. ERIC F. GIGANEK 2540 Centreville Rd, Centreville MD 21617  |  |   |   |  |   |  |   |
|  | 31. Date filed (Month, Day, Year)<br>APR 13 1999   |  | 32. Registrar's Signature<br>                                     |   |  |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





SHANON MARIE CHRISTIAN  
99-2395-027  
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16438

|  |  |   |   |  |   |   |  |  |
|--|--|---|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Shannon Marie Christian  |   |   |  | 2. Date of Death<br>Month Day Year<br>APRIL 26 1999   |   | 3. Time of Death<br>0035   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>MARYLAND ROUTE# 01   |   |   |  | 4b. City, Town, or Location of Death<br>Laurel  |   | 4c. County of Death<br>HOWARD  |  |
| Funeral<br>Director  | 5. Social Security Number<br>213 96 7421   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>18 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>June 17, 1980  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |   |   |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   | 10b. County<br>Howard   | 10c. City, Town or Location<br>Jessup   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
|  | 10e. Street and Number<br>8338 Ashwood Road  |   |   | 10f. Zip Code<br>20794   |   | 10g. Citizen of What Country?<br>USA  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (14 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Practical nurse                          |  | 16b. Kind of Business/Industry<br>Private industry  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Herman Lee Christian  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Karen Marie Amis   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Karen M. Hinton /mother  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8338 Ashwood Road, Jessup, Maryland 20794 |   |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Park   |  | 20c. Location - City or Town, State<br>Dorsey, Maryland   |   | 20d. Date<br>4/29/99   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   | 22. Name and Address of Facility<br>313 Talbott Avenue<br>Donaldson Funeral Home, P.A. Laurel, Maryland                                    |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Multiple Injuries</i><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |  |   |   |  | Approximate Interval Between Onset and Death   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE |   |  |   |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>4-26-99   |   | 28b. Time of Injury<br>0026 A.M.   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br>pedestrian hit by car   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br>O.C.M.E   |   | 29d. Date signed (Month, Day, Year)<br>APRIL 26, 1999   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201   |  |   |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 29 1999   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16439

|   |  |  |  |                                   |  |  |   |  |   |  |
|---|--|--|--|-----------------------------------|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Martha Esther Crouse</b>  |  |  |                                   | 2. Date of Death<br>Month Day Year<br><b>April 28, 1999</b>  |  |   |  | 3. Time of Death<br><b>6:30 am</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4516 Brandon Lane</b>   |  |  |                                   | 4b. City, Town, or Location of Death<br><b>Beltsville</b>  |  |   |  | 4c. County of Death<br><b>Prince George</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>111 18 1222</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                   | 7. Age (in yrs. last birthday)<br><b>72</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 26, 1926</b> |  | 9. Birthplace (State or Foreign Country)<br><b>USA New York</b>   |  |
|   | 10a. State<br><b>Maryland</b>  |  |  |                                   | 10b. County<br><b>Prince George</b>  |  | 10c. City, Town or Location<br><b>Beltsville</b>            |  |   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |                                   | 10e. Street and Number<br><b>4516 Brandon Lane</b>   |  |   |  | 10f. Zip Code<br><b>20705</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |                                   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                   |  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Postal clerk</b>   |  |  |                                   | 16b. Kind of Business/Industry<br><b>U.S. Postal Service</b>   |  |   |  | 17. Father's Name (First, Middle, Last)<br><b>Carl Edwards Angerman</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Naomi Udkowitz</b>   |  |  |                                   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Becraft/daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>801 Greenbridge Road, Brookeville, Maryland 20833</b>   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Union Cemetery</b>  |  |   |  | 20c. Location - City or Town, State<br><b>5/1/99 Burtonsville, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Laurie Danneberg</i>   |  |  |                                   | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, Maryland</b>  |  |   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Arrhythmia</b><br>Due to (or as a consequence of):<br><b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>Arteriosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>Minutes</b><br><b>Years</b><br><b>Years</b> |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Type 2 Diabetes Mellitus</b>   |  |  |                                   | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |                                   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |                                   | 28a. Date of Injury (Month, Day, Year)   |  |   |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  | 28d. Describe how injury occurred |  |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| Physician<br>/Medical<br>Examiner   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                                   | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |   |  | 29c. License number<br><b>008089</b>  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>April 28, 1999</b>   |  |  |                                   | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Michael Leibowitz, 11120 New Hampshire Ave SE, Apt 20904</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>APR 29 1999</b>   |  |
|   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |                                   | 33. State Registrar<br><b>APR 29 1999</b>  |  |   |  | 34. State Registrar   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16440

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |   |                                   |  |  |
|--|--|---|--|--|--|--|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mary B. Cossentino</b>                          |   |  |  | 2. Date of Death<br>Month Day Year<br><b>April 25 1999</b> |  |   |                                   | 3. Time of Death<br><b>9:17am</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Ridgeway Nursing Home</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |   |                                   | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-16-7814</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.           |  | If Under 1 Year<br>Months Days                      |                                   | 8. Date of Birth (Month, Day, Year)<br><b>May 2, 1919</b>                                      |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>                               |  | 10c. City, Town or Location<br><b>Ellicott City</b> |                                   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| Usual Residence of Decedent  |  | 10e. Street and Number<br><b>10318 Globe Drive</b>  |  | 10f. Zip Code<br><b>21042</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |                                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (14 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |   |                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Vincent D'Angelo</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sadie Mogioni</b>  |  |  |   |                                   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John J. Cossentino Sr./Husband</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10318 Globe Drive Ellicott City, Maryland 21042</b>                                      |  |  |   |                                   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crest Lawn Cemetery</b>  |  | Date<br><b>4-28-99</b>   |  | 20c. Location - City or Town, State<br><b>Marriottsville, MD</b>   |   |                                   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Sharon Collins-Witzke</b>  |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>   |  |  |  |  |   |                                   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br><br>b. <b>Arteriosclerotic Disease</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>many years</b>  |   |                                   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Bullous Pemphigoid</b><br><b>Coronary Artery Disease</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                                   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |   |                                   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |                                   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>Geetha Rao MD</b>   |  | 29c. License number<br><b>DA7541</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 26, 1999</b>   |   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>G. RAJA 4367 Hollins Perry Rd Baltimore, MD-21227</b>   |  |   |  |  |  |  |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 27 1999</b>  |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |  |  |   |                                   |  |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16441

|   |   |   |  |  |   |                                |   |  |                                   |
|---|---|---|--|--|---|--------------------------------|---|--|-----------------------------------|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Carmelita Caple</b>   |   |  |  | 2. Date of Death<br>Month <b>5</b> Day <b>5</b> Year <b>99</b>  |                                | 3. Time of Death<br><b>10:40 AM</b>                                     |  |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Carroll County General Hospital</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>  |                                | 4c. County of Death<br><b>Carroll</b>                                   |  |                                   |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>213-10-5906</b>   |   | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>March 15, 1919</b>            | 9. Birthplace (State or Foreign Country)<br><b>MD.</b> |                                   |
|   | Usual Residence of Decedent   |   |  |  |   |                                |   |  |                                   |
| To Be Completed by Funeral Director                     | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Carroll</b>  |  | 10c. City, Town or Location<br><b>Westminster</b>   |                                | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |  |                                   |
|   | 10e. Street and Number<br><b>805 Franklin Avenue</b>  |   |  |  | 10f. Zip Code<br><b>21157</b>   |                                | 10g. Citizen of What Country?<br><b>U. S. A.</b>                        |  |                                   |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |                                   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>own home</b>   |                                |   |  |                                   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Vincent Valianti</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephine Castellani</b>  |                                |   |  |                                   |
| To Be Completed by Physician/Medical Examiner           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Arthur Caple - son</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 Poole Road, Westminster MD 21157</b>     |                                |   |  |                                   |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sandymount Cemetery</b>   |  | 20c. Date<br><b>5-8-99</b>  |                                | 20d. Location - City or Town, State<br><b>Finksburg, MD.</b>            |  |                                   |
|   | 21. Signature of Funeral Service Licensee<br><b>John K. Ayne</b>  |   |  |  | 22. Name and Address of Facility<br><b>Pitts Funeral Home &amp; Chapel<br/>412 Washington Road<br/>Westminster, MD 21157</b>                      |                                |   |  |                                   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Massive intra cranial hemorrhage</b><br>Due to (or as a consequence of):<br><b>b. Cerebral vascular accident</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Artherosclerotic Cardiovascular disease.</b><br><b>Coronary artery disease</b> |   |  |  |   |                                |   |  |                                   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Artherosclerotic Cardiovascular disease.</b><br><b>Coronary artery disease</b>   |   |  |  |   |                                |   |  |                                   |
| State<br>Registrar                                      | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |                                |   |  |                                   |
|   | 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |  | 28d. Describe how injury occurred |
|   | 29a. Certifier (Check only one)<br><b>1</b> Medical Examiner  |   | 29b. Signature and title of certifier<br><b>Khairi Figei MD</b>  |  |   |                                |   |  |                                   |
|   | 29c. License number<br><b>038915</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>5/5/99</b>   |  |   |                                |   |  |                                   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FREIJ 295 HONOR AVE WESTMINSTER MD 21157</b>   |   |  |  |   |                                |   |  |                                   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b> |   | 32. Registrar's Signature<br><b>B. Sparks</b> |  |  |   |                                |   |  |                                   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



On 23rd July 1962  
at 10.15 AM  
The following was received from the  
Director of the Department of the Interior

Re: [illegible]  
[illegible]  
[illegible]

On 23rd July 1962  
at 10.15 AM  
The following was received from the  
Director of the Department of the Interior  
[illegible]  
[illegible]  
[illegible]

On 23rd July 1962  
at 10.15 AM  
The following was received from the  
Director of the Department of the Interior  
[illegible]  
[illegible]  
[illegible]

On 23rd July 1962  
at 10.15 AM  
The following was received from the  
Director of the Department of the Interior  
[illegible]  
[illegible]  
[illegible]

On 23rd July 1962  
at 10.15 AM  
The following was received from the  
Director of the Department of the Interior  
[illegible]  
[illegible]  
[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16442

Certificate of Death

Reg. No.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES EDWARD COOLAHAN, SR.</b>                   |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 30 1999</b> |  | 3. Time of Death<br><b>6:30 AM</b>                          |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b> |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>                           |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-05-3427</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.           | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 29, 1921</b>  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|   | Usual Residence of Decedent   |   |  |  |   |
| 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>ANNE ARUNDEL</b>  |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>  |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>1106 ARMISTEAD STREET</b>  |  | 10f. Zip Code<br><b>21061</b>  |   |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-1945</b> |   |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>LETTER CARRIER</b>                       |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LETTER CARRIER</b>  |   | 16b. Kind of Business/Industry<br><b>U.S. POSTAL SERVICE</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM H. COOLAHAN</b>  |   |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BLANCHE GRUMMLIN</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>SHIRLEY COOLAHAN (WIFE)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1106 ARMISTEAD STREET, GLEN BURNIE, MD. 21061</b>                  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK</b>  |  | 20c. Location - City or Town, State<br><b>ELKRIDGE, MD.</b>  |   |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. VENTRICULAR FIBRILLATION</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>1 HR</b><br><b>10 YR</b>   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                 |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |
| 29b. Signature and title of certifier<br> M.D.   |   | 29c. License number<br><b>P: 11950</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 30 1999</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PIYUSH PATEL HARBOR HOSPITAL CENTER</b>  |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 03 1999</b>   |   | 32. Registrar's Signature<br>  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Division of Vital Records, P.O. Box 68760,

RECEIVED THE ...  
...  
...

...  
...  
...

...  
...  
...

...  
...  
...

...  
...  
...

...  
...  
...  
PUB. 81. 742

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16443

Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |  |  |
|---|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>ARTHUR O. CROWLEY JR.                            |   |   |   | 2. Date of Death<br>Month Day Year<br>MAY 01, 1999 |  | 3. Time of Death<br>0412 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>DOCTORS COMMUNITY HOSPITAL |   |   |   | 4b. City, Town, or Location of Death<br>LANHAM     |  | 4c. County of Death<br>PRINCE GEORGES  |  |
| Funeral<br>Director   | 5. Social Security Number<br>434-50-2061   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>60 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>11/23/38  |  | 9. Birthplace (State or Foreign Country)<br>Louisiana                            |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |  |
| 10a. State<br>MD  |  | 10b. County<br>P.G.   |   | 10c. City, Town or Location<br>Bowie  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br>12431 Melling Lane  |  |   |   | 10f. Zip Code<br>20715  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1956<br>If Yes, Give Year or Dates: 1960 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                               |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 5+  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>PASTOR   |  |  | 16b. Kind of Business/Industry<br>CHURCH   |  |
| 17. Father's Name (First, Middle, Last)<br>Arthur O. Crowley Sr.  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bessie Wishem  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Verbena Crowley wife  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12431 Melling Lane Bowie, Md. 20715  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cem.  |  | 20c. Location - City or Town, State<br>5/6/99 Brentwood, MD.   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>James Edwards</i>   |  |   |   | 22. Name and Address of Facility<br>Hodges and Edwards<br>3910 Silver Hill RD. Suitland, Md. 20746  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. CANCER OF LIVER<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |  |  | Approximate Interval Between Onset and Death                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DIABETES MELLITUS   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|   |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |
|   |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   | 29b. Signature and title of certifier<br><i>James Edwards</i>   |  | 29c. License number<br>D33954  |  | 29d. Date signed (Month, Day, Year)<br>MAY 02, 1999                              |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>MARLO F. GLOVE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785  |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 03 1999  |  |   |   | 32. Registrar's Signature<br><i>B. Spauld</i>   |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend item # 8. PGC 5-4-99 cr

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sylvia K. Crowley

2. Date of Death

Month Day Year  
April 30, 1999

3. Time of Death

9:25 A.M.

4a. Facility Name (If not institution, give street and number)

5703 Newington Rd.

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

577-60-4209

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 1908  
Jan. 27, 1999

9. Birthplace (State or Foreign Country)

Maine

Usual Residence of Decedent

10a. State

MD.

10b. County

Montgomery

10c. City, Town or Location

Bethesda, Maryland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5703 Newington Rd.

10f. Zip Code

20816

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Payroll Officer

16b. Kind of Business/Industry

US. Government

17. Father's Name (First, Middle, Last)

William L. Crowley

18. Mother's Name (First, Middle, Maiden Summa)

Mary Hayes

19a. Informant's Name/Relationship (Type, Print)

Jane Clancy - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5703 Newington Rd. Bethesda, MD. 20816

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Olivet Cemetery 5-4-99

Data

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Joseph Gawler's Sons

22. Name and Address of Facility

5130 Wisconsin Ave. NW. Wash. DC 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Stroke

Due to (or as a consequence of):

hours

b. Cerebro Vascular Disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Russell M. Tilley, M.D.

29c. License number

#D11888, 1999

29d. Date signed (Month, Day, Year)

April 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell M. Tilley, M.D. 4701 Massachusetts Avenue, N.W., Washington, D.C. 20016

31. Date filed (Month, Day, Year)

MAY 04 1999

Registrar's Signature

B. Jones

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16445

|  |  |   |   |                                       |  |   |  |   |  |
|--|--|---|---|---------------------------------------|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Lola H. Curry</b>   |   |   |                                       | 2. Date of Death<br>Month <b>May</b> Day <b>6</b> , Year <b>1999</b>   |   | 3. Time of Death<br><b>4:15AM</b>  |   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Bradford Oaks Nursing Home</b>  |   |   |                                       | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |   | 4c. County of Death<br><b>Prince George's</b>  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>184-22-5623</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |                                       | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>10/03/08</b>   |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>King George, VA.</b>  |   | 10a. State<br><b>Maryland</b>   |                                       | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>Temple Hills</b>   |   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |                                       | 10e. Street and Number<br><b>5609 Lambert Dr.</b>  |   |  |   |  |
|  | 10f. Zip Code<br><b>20748</b>  |   |   |                                       | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b>  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Restaurant Worker</b>              |                                       | 16b. Kind of Business/Industry<br><b>Food Industry</b>   |   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Oscar Howell</b>   |   |   |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susie Jordan</b>   |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lois C. Carroll/Daughter</b>  |   |   |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as item 10</b>  |   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |                                       | 20c. Location - City or Town, State<br><b>Alexandria, VA.</b>  |   | 20d. Date<br><b>05/06/99</b>   |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |                                       | 22. Name and Address of Facility<br><b>George P. Kalas Funeral Home, P.A.<br/>6160 Oxon Hill Rd. Oxon Hill, MD. 20745</b>  |   |  |   |  |
|  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Acute myocardial infarction</b><br>Due to (or as a consequence of):<br>b. <b>Alzheimer dementia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Due to (or as a consequence of): |   |   |                                       |  |   |  | Approximate Interval Between Onset and Death<br><b>1 hr</b><br><b>5 w</b> |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                                       |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |                                       |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                       |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>2-24535</b> |  | 29d. Date signed (Month, Day, Year)<br><b>May 6, 1999</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Laxmi N. Berwa, M.D. 7701 Old Branch Ave. Clinton, MD. 20735</b>  |  |   |   |                                       |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 06 1999</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |                                       |  |   |  |   |  |

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

?

902 31 2/67

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16446

|  |  |                                  |  |   |   |   |   |   |
|--|--|----------------------------------|--|---|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CARROLL S. COBLE</b>  |                                  |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>4</b> , Year <b>1999</b>  |   | 3. Time of Death<br><b>8:20 p.m.</b>                          |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health Care of Kensington</b> |                                  |  |   | 4b. City, Town, or Location of Death<br><b>Kensington</b>   |   | 4c. County of Death<br><b>Montgomery</b>                      |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>231-16-8674</b>  |                                  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 9, 1920</b>    | 9. Birthplace (State or Foreign Country)<br><b>Alabama</b>              |
|  | Usual Residence of Decedent  |                                  |  |   |   |   |   |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b> |  | 10c. City, Town or Location<br><b>Kensington</b>  |   |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No           |   |
| 10e. Street and Number<br><b>3000 McCombas Ave.</b>  |  |                                  |  | 10f. Zip Code<br><b>20895</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>   |   |   |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>5+</b>  |  |                                  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Professor</b> |   |   | 16b. Kind of Business/Industry<br><b>Government</b>           |   |
| 17. Father's Name (First, Middle, Last)<br><b>Ennis C. Coble</b>   |  |                                  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Etta Wynn</b>   |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ennis C. Doyle - Sister</b>   |  |                                  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4266 E. Capitol St., N.E. Wash., D.C. 20019</b> |   |   |   |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Thatche-Mann Cemetery</b>   |   | Date<br><b>5/10/99</b>  |   | 20c. Location - City or Town, State<br><b>Athens, Alabama</b> |   |
| 21. Signature of Funeral Service Licensee<br><i>John T. Stewart III</i>  |  |                                  |  |   | 22. Name and Address of Facility<br><b>Stewart Funeral Home</b><br><b>4001 Benning Rd., N.E. Wash., D.C. 20019</b>                                  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> |  |                                  |  |   |   |   |   | Approximate Interval Between Onset and Death                            |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |   |   |
|  |  |                                  |  |   |   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |   |   |
|  |  |                                  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |   |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  |                                  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |   |   |   |   |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  |                                  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No              |   |
|  |  |                                  | 28d. Describe how injury occurred  |   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                  | 29b. Signature and title of certifier<br><i>Susan Leggett - Johnson MD</i>   |   |   | 29c. License number<br><b>D38149 MD</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/6/99</b>                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6525 Belcrest Road Hyattsville, Md 20785</b>  |  |                                  |  |   |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>  |  |                                  | 32. Registrar's Signature<br><i>Brown S. Smith</i>   |   |   |   |   |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16447

## Certificate of Death

Reg. No.

|  |   |                                      |   |   |  |  |  |  |                                   |  |
|--|---|--------------------------------------|---|---|--|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GLADYS HALL CROSSON</b>                                  |                                      |   |   | 2. Date of Death<br>Month Day Year<br><b>MAY 4, 1999</b>   |  | 3. Time of Death<br><b>17:15 PM</b>  |  |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |                                      |   |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>179-22-3049</b>   |                                      | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 24, 1911</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |                                   |  |
|  | Usual Residence of Decedent   |                                      |   |   |  |  |  |  |                                   |  |
| 10a. State<br><b>MD.</b>   |   | 10b. County<br><b>MONTGOMERY CO.</b> |   | 10c. City, Town or Location<br><b>DAMASCUS</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                                   |  |
| 10e. Street and Number<br><b>27601- BARNES ROAD</b>  |   |                                      |   | 10f. Zip Code<br><b>20750</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                          |  |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>12</b>  |   |                                      |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                   |  | 16b. Kind of Business/Industry<br><b>AT HOME</b>   |  |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>G. WALTER HALL</b>   |   |                                      |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EMMA SADLER</b>   |  |  |  |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARION SCULLIN- DAUGHTER</b>  |   |                                      |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27601- BARNES ROAD, DAMASCUS, MD. 20750</b> |  |  |  |  |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>UNIONVILLE CEMETERY</b>  |   | Date<br><b>5/8/99</b>  |  | 20c. Location - City or Town, State<br><b>UNIONVILLE, PA.</b>                                    |  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                                      |   | 22. Name and Address of Facility<br><b>HYSONG CO., INC.<br/>1300- N ST., NW, WASH., DC</b>  |  |  |  |  |                                   |  |
| 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Perforated peptic ulcer</b><br>Due to (or as a consequence of):<br><br>b. <b>Acute renal failure</b><br>Due to (or as a consequence of):<br><br>c. <b>congestive heart failure</b><br>Due to (or as a consequence of):<br><br>d. |   |                                      |   |   |  |  |  | Approximate Interval Between Onset and Death<br><br>days<br><br>days<br><br>years  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                      |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |                                   |  |
|  |   |                                      |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   |                                      | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No             |  | 28d. Describe how injury occurred |  |
|  |   |                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                     |  |                                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                                      |   |   |  |  |  |  |                                   |  |
| 29b. Signature and title of certifier<br>   |   |                                      |   | 29c. License number<br><b>D 31391</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>May 04 1999</b>  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SUHAIR ABULFURAGI - 481 N. FREDERICK RD., GAITHERSBURG, MD. 20877</b>   |   |                                      |   |   |  |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 06 1999</b>  |   |                                      | 32. Registrar's Signature<br>  |   |  |  |  |  |                                   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-368-6000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar

1. The first part of the report is a general description of the project and its objectives. This section should be written in a clear and concise manner, using simple language that is easy to understand. It should also include a brief overview of the project's history and the current status of the work.

2. The second part of the report is a detailed description of the project's methodology. This section should describe the methods used to collect and analyze data, and should include a discussion of the strengths and limitations of these methods. It should also include a discussion of the ethical considerations that were taken into account during the project.

3. The third part of the report is a discussion of the project's results. This section should describe the findings of the project, and should include a discussion of the implications of these findings for the field of study. It should also include a discussion of the limitations of the project and the need for further research.

4. The fourth part of the report is a conclusion. This section should summarize the main findings of the project, and should include a discussion of the overall impact of the project on the field of study. It should also include a discussion of the future directions of the project and the need for further research.

5. The fifth part of the report is a list of references. This section should include a list of all the sources that were used in the project, and should be formatted according to the appropriate style guide. It should also include a list of all the people who were involved in the project, and their roles.

6. The sixth part of the report is an appendix. This section should include any additional information that is relevant to the project, such as raw data, code, or other materials. It should be formatted according to the appropriate style guide, and should be included as a separate section at the end of the report.

7. The seventh part of the report is a list of figures. This section should include a list of all the figures that were used in the project, and should be formatted according to the appropriate style guide. It should also include a list of all the tables that were used in the project, and their contents.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16448

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARVIN GRAYDON DAUGHERTY

2. Date of Death

Month  
MAYDay  
10Year  
1999

3. Time of Death

7:00 P.M.

4a. Facility Name (If not institution, give street and number)

FREDERICK HEALTH CARE CENTER

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral  
Director

5. Social Security Number

570-36-4244

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 4, 1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

ROHRERSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3937 Rohrersville Road

10f. Zip Code

21779

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STONE MASON

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ROY DAUGHERTY

18. Mother's Name (First, Middle, Maiden Surname)

EDNA DANCEY

19a. Informant's Name/Relationship (Type, Print)

JOSEPHINE DAUGHERTY/SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 75, ROHRERSVILLE, MARYLAND 21779

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SAMPLES MANOR CEMETERY

Date

5/13/99

20c. Location - City or Town, State

SHARPSBURG, MARYLAND

21. Signature of Funeral Service Licensee

Paul M. Dean

22. Name and Address of Facility

BAST FUNERAL HOME

7606 Old National Pike  
Boonsboro, Maryland 21713

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CVA

e.

Due to (or as a consequence of):

b.

Diabetic Mellitus

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2199

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James S. Grissom, M.D.

29c. License number

D21944

29d. Date signed (Month, Day, Year)

5/12/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James S. Grissom, M.D. 300 West 9th Street, Frederick, MD 21701

31. Date filed (Month, Day, Year)

MAY 12 1999

32. Registrar's Signature

G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16449

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |                                |  |  |
|--|--|---|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALICE NMN DOWNEY</b>  |  |   |  | 2. Date of Death<br>Month <b>May</b> Day <b>5</b> Year <b>1999</b>  |                                | 3. Time of Death<br><b>12:30 AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>16505 Virginia Avenue</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Williamsport</b>   |                                | 4c. County of Death<br><b>Washington</b>   |  |
| 5. Social Security Number<br><b>213-18-9795</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>March 5, 1921</b>                                    |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |   |                                |  |  |
| Usual Residence of Decedent  |  |   |  |   |                                |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Washington</b>  |  | 10c. City, Town or Location<br><b>Williamsport</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>16505 Virginia Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21795</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br><b>4</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |                                | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ray F. Rohrer</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Hollyday</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Suzanne D. Hayes</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9101 Downsville Pike, Williamsport, Md. 21795</b>   |                                |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery</b>   |  | Date<br><b>05-08-99</b>   |                                | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>                             |  |
| 21. Signature of Funeral Service Licensee<br><b>L. Noel Brady</b>  |  |   |  | 22. Name and Address of Facility<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 East Antietam Street, Hagerstown, Md. 21740</b>  |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |                                |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |  |   |  |   |                                |  |  |
| a. <b>Acute myocardial infarction</b> Due to (or as a consequence of): <b>1 hour</b>   |  |   |  |   |                                |  |  |
| b. <b>Coronary Artery Disease</b> Due to (or as a consequence of): <b>5 years</b>  |  |   |  |   |                                |  |  |
| c. Due to (or as a consequence of):  |  |   |  |   |                                |  |  |
| d. Due to (or as a consequence of):  |  |   |  |   |                                |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |                                |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |                                |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b>  |  |   |  |   |                                |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how Injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |                                |  |  |
| 29b. Signature and title of certifier<br><b>Michael J. McCormack MD</b>  |  |   |  | 29c. License number<br><b>041667</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>5.5.99</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael J. McCormack 11110 Medical Campus Rd Suite 130 Hagerstown, MD</b>   |  |   |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 06 1999</b>  |  |   |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |                                |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16450

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |   |
|--|--|--|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>William Thomas Davis Sr.   |  |   |  | 2. Date of Death<br>Month Day Year<br>April 18, 1999   |  | 3. Time of Death<br>7:00 AM                                      |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>208 Elm Street   |  |   |  | 4b. City, Town, or Location of Death<br>Centreville  |  | 4c. County of Death<br>Queen Anne's                              |   |
| Funeral<br>Director  | 5. Social Security Number<br>579-48-6557   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>69 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Aug. 31, 1929             |   |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |  |  |  |  |   |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |   |  |  |  |  |   |
|  | 10a. State<br>Md.  | 10b. County<br>Queen Anne's  | 10c. City, Town or Location<br>Centreville  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
|  | 10e. Street and Number<br>208 Elm Street   |  |   | 10f. Zip Code<br>21617   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korea |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Soil Conservationalist                         |  | 16b. Kind of Business/Industry<br>U. S. Govt.  |  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Harold Adams Davis  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Nelson   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>W. Thomas Davis Jr. Son  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>117 Carriage Lane, Queenstown, Md. 21658      |  |  |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Apr. 21, 1999 Rehobeth, Md.<br>Rehobeth Presbyterian Church Cemetery |  |  |  |   |
| 21. Signature of Funeral Service Licensee<br>Thomas K. [Signature]   |  |  |   | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home<br>408 S. Liberty St., Centreville, Md.                          |  |  |  |   |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cirrhosis of the liver with esophageal varices, GI bleeding and anasarca<br>Due to (or as a consequence of):<br>b. [blank]<br>Due to (or as a consequence of):<br>c. [blank]<br>Due to (or as a consequence of):<br>d. [blank]<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br>minutes |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic obstructive lung disease   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No    |  |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
| 28d. Describe how injury occurred  |  |  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |   |  |  |  |  |   |
| 29b. Signature and title of certifier<br>Robert W. Trever, M.D.  |  |  |   | 29c. License number<br>D10938  |  | 29d. Date signed (Month, Day, Year)<br>04-19-99  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert W. Trever, M.D.; 7696 Ocean Gateway, Easton, Md. 21602  |  |  |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>APR 20 1999   |  | 32. Registrar's Signature<br>[Signature]   |   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

ITEM: #14 PER INFORMAT G772 6-9-99 WR.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND DORSEY

2. Date of Death

Month  
MAYDay  
1Year  
1999

3. Time of Death

1124

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

218-32-8955

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
May 8, 1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Marriottsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11273 Old Frederick Road

10f. Zip Code

21104

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ~~White~~ BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cement Finisher

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Jarrett Dorsey

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Jordan

19a. Informant's Name/Relationship (Type, Print)

Mrs. Miriam A. Dorsey (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11273 Old Frederick Road Marriottsville, MD 21104

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crestlawn Mem. Gardens

Date

5/5/99

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

Brian L. Haight

22. Name and Address of Facility

Haight Funeral Home & Chapel, PA (Box 195)  
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

less than 30 minutes

years

Sequently list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

NIDDM

History cerebral vascular accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jay Stern, M.D.

29c. License number

D34206

29d. Date signed (Month, Day, Year)

5/1/99

30. Name and address of person who completed cause of death (Item 23b) (Type, Print)

Jay Stern, M.D. 3110 Route 32, W. Friendship MD 21794

31. Date filed (Month, Day, Year)

MAY 10 1999

32. Registrar's Signature

Benita B. Sparks

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16452

|   |   |  |  |   |  |  |   |   |
|---|---|--|--|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>PETER (NMN) DEMBROWICZ</b>                       |  |  |   | 2. Date of Death<br>Month Day Year<br><b>May 5 1999</b>    |  | 3. Time of Death<br><b>11:55 PM</b>                         |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b> |  | 4c. County of Death<br><b>Anne Arundel</b>                  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>071-18-4785</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 23, 1923</b> | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b> |
|   | Usual Residence of Decedent   |  |  |   |  |  |   |   |
| 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>ANNE ARUNDEL</b>   |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
| 10e. Street and Number<br><b>305 GLENWOOD AVENUE</b>  |   |  |  | 10f. Zip Code<br><b>21061</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-1945</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TOOL AND DYE REPAIRMAN</b>  |  | 16b. Kind of Business/Industry<br><b>STEEL WORKER</b>  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>VLADIMIR DEMBROWICZ</b>   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KATHERINE ZURAWSKA</b>  |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARGARET DEMBROWICZ (WIFE)</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>305 GLENWOOD AVENUE, GLEN BURNIE, MD. 21061</b>   |  |  |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>5/10/99 GLEN BURNIE, MD.</b>   |   |   |
| 21. Signature of Funeral Service licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>  |  |  |   |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, but only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br><b>b. PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |   |  |  |   | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>* RENAL FAILURE*, CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br/>* CONGESTIVE HEART FAILURE<br/>* CORONARY ARTERY DISEASE<br/>* GASTROINTESTINAL BLEEDING<br/>* H/O CARCINOMA PROSTATE</b>  |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred                           |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |  |   |  |  |   |   |
| 29b. Signature and title of certifier<br> MD   |   |  |  | 29c. License number<br><b>DS1245</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 6, 1999</b>  |   |   |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>SAJID SHARIF NORTH ARUNDEL HOSPITAL - MD</b>   |   |  |  |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>   |   |  |  | 32. Registrar's Signature<br>  |  |  |   |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Dembrowicz, Peter

1. *Journal of the American Medical Association*, 1997; 278: 1039-1044.

2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 2686, 2687, 2688, 26

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16453

|   |   |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|---|---|---|---|---|--|--|---|--|---|----------------------------------|----------------------------------|---|----|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Betty J. Diest</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>May 4, 1999</b>   |  | 3. Time of Death<br><b>7:00 am</b>                                      |  |   |                                  |                                  |   |    |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health Care</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Laurel</b>  |  | 4c. County of Death<br><b>Prince George's</b>                           |  |   |                                  |                                  |   |    |    |
| Funeral<br>Director   | 5. Social Security Number<br><b>172-18-3628</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>June 18, 1927</b>             |  |   |                                  |                                  |   |    |    |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>Laurel</b>                            |  |   |                                  |                                  |   |    |    |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   | 10e. Street and Number<br><b>14200 Laurel Park Drive</b>   |  |   |  |   |                                  |                                  |   |    |    |
|   | 10f. Zip Code<br><b>20707</b>   |   |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |   |                                  |                                  |   |    |    |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                                  |                                  |   |    |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |   |                                  |                                  |   |    |    |
|   | 17. Father's Name (First, Middle, Last)<br><b>Chauncey Tressler</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Vena Burley</b>  |  |   |  |   |                                  |                                  |   |    |    |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mildred Hymowitz - Daughter</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4600 Cherokee Street, College Park, Maryland 20740</b>                                       |  |   |  |   |                                  |                                  |   |    |    |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>I.O.O.F. Cemetery</b>  |   | Date<br><b>05/07/99</b>  |  | 20c. Location - City or Town, State<br><b>Berlin, Pennsylvania</b>      |  |   |                                  |                                  |   |    |    |
|   | 21. Signature of Funeral Service Licensee<br><b>Claudette J. Gasch</b>  |   |   |   | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>   |  |   |  |   |                                  |                                  |   |    |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Neoplasm Colon</b></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>1 yr</b></td> </tr> <tr> <td>b. </td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table> |   |   |   |  |  |   |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Neoplasm Colon</b>         | Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>1 yr</b> | b. | c. |
| Immediate Cause (Final disease or condition resulting in death)   | a. <b>Neoplasm Colon</b>  | Due to (or as a consequence of):  | Approximate Interval Between Onset and Death<br><b>1 yr</b>   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|   | b.  |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|   | c.  |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|   | d.  |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
| <table border="1"> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. </td> <td rowspan="4">Due to (or as a consequence of):</td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> <tr> <td>d. </td> </tr> </table>   |   |   |   |   |  |  |   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b.  | Due to (or as a consequence of): | c.                               | d.  | d. |    |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b.  | Due to (or as a consequence of):  |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|   | c.  |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|   | d.  |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
|   | d.  |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |   |                                  |                                  |   |    |    |
|   |   |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |                                  |                                  |   |    |    |
|   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |                                  |                                  |   |    |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>               |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |                                  |                                  |   |    |    |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28d. Describe how injury occurred   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
| 29b. Signature and title of certifier<br><b>Andrew Kondrat M.D.</b>   |   |   |   | 29c. License number<br><b>036716</b>          |  | 29d. Date signed (Month, Day, Year)<br><b>May 4, 1999</b>  |   |  |   |                                  |                                  |   |    |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. Kondrat, M.D., 8317 Cherry Lane, Laurel, Maryland 20707</b>   |   |   |   |   |  |  |   |  |   |                                  |                                  |   |    |    |
| 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>   |   |   |   | 32. Registrar's Signature<br><b>B. Spauld</b> |  |  |   |  |   |                                  |                                  |   |    |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16454

G773 6-13-99 J.A.

AMEND ITEM#10a-10c&amp;10e&amp;f PER F.H. #26-PHYNS

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |                                |  |  |
|---|---|--|---|---|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>BRENDA M.S. DUNCAN  |  |   |   | 2. Date of Death<br>Month Day Year<br>05 05 99   |                                | 3. Time of Death<br>6:24 pm  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1420 Albert Drive   |  |   |   | 4b. City, Town, or Location of Death<br>Mitchellville  |                                | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>232-72-5762  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>57 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>December 6, 1941  | 9. Birthplace (State or Foreign Country)<br>West Virginia  |
|   | Usual Residence of Decedent   |  |   |   | 10c. City, Town or Location<br>Mitchellville PHILADELPHIA  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director           | 10a. State<br>PENNSYLVANIA Maryland   |  | 10b. County<br>PRINCE GEORGE'S  |   | 10c. City, Town or Location<br>MITCHELLVILLE PHILADELPHIA  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>1420 Albert Drive   |  |   |   | 10f. Zip Code<br>20721 19150   |                                | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Special Education Teacher                |   | 16b. Kind of Business/Industry<br>Government   |                                |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Joseph S. Saundle  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lucille Harper  |                                |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Dr. Elliece S. Smith/Sister   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1420 Albert Drive, Mitchellville, Maryland 20721  |                                |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Lawn Cemetery  |   | Date<br>05/10 1999   |                                | 20c. Location - City or Town, State<br>Princeton, West Virginia                                    |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Beha J. Jenkins</i>   |  | 22. Name and Address of Facility<br>J.B. JENKINS FUNERAL HOME<br>7474 Landover Road, Landover, Maryland 20785   |   |  |                                |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>e. <u>Pneumonia</u><br>Due to (or as a consequence of):<br>b. <u>Complications of Advanced Lupus</u><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____         |  |   |   |  |                                |  | Approximate Interval Between Onset and Death<br>2 days<br>7 years  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |   |  |                                |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |  |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |                                |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SISTER'S HOME  |  |   |   |  |                                |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |                                |  |  |
| State Registrar                               | 29b. Signature and title of certifier<br><i>Gary W. Jones MD</i>  |  |   |   | 29c. License number<br>D30111  |                                | 29d. Date signed (Month, Day, Year)<br>May 6, 1999   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gary W. Jones MD 9723 Country Meadows Lane 2B Laurel MD 20723   |  |   |   |  |                                |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>MAY 07 1999  |  |   |   | 32. Registrar's Signature<br><i>Gary W. Jones</i>  |                                |  |  |
|   |   |  |   |   |  |                                |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

2007 10 10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

James Elmer Elburn

2. Date of Death  
Month Day Year

April 14 1999

3. Time of Death

4:15PM

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

212-40-7703

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 5, 1942 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne's

10c. City, Town or Location

Centreville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

100 Clarks Corner Road

10f. Zip Code

21617

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farming

16b. Kind of Business/Industry

Donald Leager  
Farm

17. Father's Name (First, Middle, Last)

Willie Earl Elburn

18. Mother's Name (First, Middle, Maiden Sumama)

Bertha Mae Roe

19a. Informant's Name/Relationship (Type, Print) (Friend)

Donald Leager (Employer)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 Clarks Corner Rd., Centreville, Md. 21617

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Stevensville Cemetery

Date

April 17, 1999

20c. Location - City or Town, State

Stevensville, Md.

21. Signature of Funeral Service Licensee

*Amey Michieny*

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home  
408 S. Liberty St., Centreville, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Bowel Infarction*  
Due to (or as a consequence of):  
b. *Tobacco Abuse*  
Due to (or as a consequence of):  
c.   
Due to (or as a consequence of):  
d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*5 days*  
*30 years*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Alcoholism*

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Russell Schilling*

29c. License number

*7142587*

29d. Date signed (Month, Day, Year)

*4/14/99*

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Russell Schilling, D.O.; 2540 Centreville Rd., Centreville, Md. 21617

31. Date filed (Month, Day, Year)

*APR 16 1999*

32. Registrar's Signature

*B. Sparks*

State  
Registrar

James Elburn  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended #5, 5/10/99, Howard Co., M.W.O.

Reg. No.

99 16456

JUANITA FUNKHOUSER MAY 2, 1999 9:00 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|  |  |  |  |  |                                |   |   |  |  |
|--|--|--|--|--|--------------------------------|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Juanita Mae Funkhouser</b>  |  |  |  |  |                                | 2. Date of Death<br>Month Day Year<br><b>May 2 1999</b>   |   | 3. Time of Death<br><b>9:00pm</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Timonium</b>  |                                | 4c. County of Death<br><b>Baltimore</b>   |   |  |  |
| 5. Social Security Number<br><b>unk. 216-30-9943</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>Apr 9, 1931</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |  |
| Usual Residence of Decedent  |  |  |  |  |                                |   |   |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Columbia</b>   |                                |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>5870 Stevens Forest Road</b>  |  |  |  | 10f. Zip Code<br><b>21045</b>  |                                | 10g. Citizen of What Country?<br><b>United States</b>   |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |                                |   | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Clinton George Davidson</b>  |  |  |  |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine Smith</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Roger A. Funkhouser/Son</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RR 7 Box 7655 Spring Grove, Pennsylvania 17362</b>                                       |                                |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Good Shepherd Cemetery</b>  |  | Date<br><b>5-5-99</b>  |                                | 20c. Location - City or Town, State<br><b>Ellicott City, MD</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>  |                                |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>BLADDER CANCER</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |                                |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
|  |  |  |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
|  |  |  |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |                                |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |                                |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D43527</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>5/14/99</b>   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093</b>  |  |  |  |  |                                |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 06 1999</b>  |  | 32. Registrar's Signature<br>  |  |  |                                |   |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16457

|  |  |                                       |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
|--|--|---------------------------------------|---|---|---|--|--|--|--|--|--|---|---|---------------------------------------|---|-------------------------------------|-------------------------|-------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Jesse Grace FRENCH                     |                                       |   |   |   |  | 2. Date of Death<br>Month Day Year<br>May 9, 1999  |  |  | 3. Time of Death<br>9:40 a.m.  |  |   |   |                                       |   |                                     |                         |                                     |
|  | 4a. Facility Name (If not Institution, give street and number)<br>1612 Howell Road |                                       |   |   |   |  | 4b. City, Town, or Location of Death<br>Hagerstown |  |  | 4c. County of Death<br>Washington  |  |   |   |                                       |   |                                     |                         |                                     |
| Funeral<br>Director  | 5. Social Security Number<br>216-07-0530   |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>84 Yrs. |  | If Under 1 Year<br>Months Days                     |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 12, 1915             |  | 9. Birthplace (State or Foreign Country)<br>Maryland |   |   |                                       |   |                                     |                         |                                     |
|  | Usual Residence of Decedent  |                                       |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 10a. State<br>Maryland   |  | 10b. County<br>Washington             |   | 10c. City, Town or Location<br>Hagerstown   |   |  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   |                                       |   |                                     |                         |                                     |
| 10e. Street and Number<br>1612 Howell Road   |  |                                       |   | 10f. Zip Code<br>21740  |   |  |  | 10g. Citizen of What Country?<br>USA   |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white |  |  |   |   |                                       |   |                                     |                         |                                     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 1   |  |                                       |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>executive secretary  |   |  |  | 16b. Kind of Business/Industry<br>aircraft manufacturer                              |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 17. Father's Name (First, Middle, Last)<br>John William Clark, Sr.   |  |                                       |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Susan Izora Spring  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 19a. Informant's Name/Relationship (Type, Print)<br>George Michael - nephew  |  |                                       |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11248 Big Pool Road, Big Pool, Maryland 21711   |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                                       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery   |   |  |  | Date<br>5-12-99  |  | 20c. Location - City or Town, State<br>Hagerstown, Maryland  |  |   |   |                                       |   |                                     |                         |                                     |
| 21. Signature of Funeral Service Licensee<br>Robert H. Haines  |  |                                       |   |   |   | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740   |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |                                       |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td rowspan="4">{</td> <td>a. BRONCHIOGENIC CARCINOMA (PRESUMED)</td> <td rowspan="4">Approximate Interval Between Onset and Death<br/>YEARS</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. ASTHMATIC BRONCHITIS</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table> |  |                                       |   |   |   |  |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | { | a. BRONCHIOGENIC CARCINOMA (PRESUMED) | Approximate Interval Between Onset and Death<br>YEARS | b. Due to (or as a consequence of): | c. ASTHMATIC BRONCHITIS | d. Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | {  | a. BRONCHIOGENIC CARCINOMA (PRESUMED) | Approximate Interval Between Onset and Death<br>YEARS   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
|  |  | b. Due to (or as a consequence of):   |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
|  |  | c. ASTHMATIC BRONCHITIS               |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
|  |  | d. Due to (or as a consequence of):   |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>EMPHYSEMA  |  |                                       |   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |   |                                       |   |                                     |                         |                                     |
| 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                       |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                       |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |                                       |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |   |   |                                       |   |                                     |                         |                                     |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                       |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                       |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 29b. Signature and title of certifier<br>D. W. WUSTE MD  |  |                                       |   |   |   | 29c. License number<br>A22043  |  |  | 29d. Date signed (Month, Day, Year)<br>5/10/99                   |  |  |   |   |                                       |   |                                     |                         |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>11110 MEDICAL CAMPUS RD. #130 HAGERSTOWN, MD 21742   |  |                                       |   |   |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |
| 31. Date filed (Month, Day, Year)<br>MAY 11 1999   |  |                                       |   | 32. Registrar's Signature<br>B. Sparks  |   |  |  |  |  |  |  |   |   |                                       |   |                                     |                         |                                     |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Amended/Line 4.  
Line 17. Line 19a.  
SC 5-11-99 WCHD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

09-16458

|  |   |                                  |  |   |  |  |   |  |                                   |   |  |
|--|---|----------------------------------|--|---|--|--|---|--|-----------------------------------|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN CORNELIUS FOSTER JR.</b>                        |                                  |  |   | 2. Date of Death<br>Month <b>MAY</b> Day <b>7</b> Year <b>1999</b>   |  | 3. Time of Death<br><b>2134</b>   |  |                                   |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington County Hospital</b> |                                  |  |   | 4b. City, Town, or Location of Death<br><b>Hagerstown</b>  |  | 4c. County of Death<br><b>Washington</b>  |  |                                   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>894-26-9887</b>   |                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br><b>February 24, 1936</b>                             |  |                                   |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |                                  |  |   |  |  |   |  |                                   |   |  |
| Usual Residence of Decedent  |   |                                  |  |   |  |  |   |  |                                   |   |  |
| 10e. State<br><b>Maryland</b>  |   | 10b. County<br><b>Washington</b> |  | 10c. City, Town or Location<br><b>Hagerstown</b>  |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                   |   |  |
| 10e. Street and Number<br><b>1021-C Noland Drive</b>   |   |                                  |  | 10f. Zip Code<br><b>21740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b> |   |  |                                   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1955-1959</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |                                   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |   |                                  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electronic Engineer</b> |  |  | 16b. Kind of Business/Industry<br><b>Aerospace Company</b>                                  |  |                                   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Cornelius Foster Sr.</b>  |   |                                  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Marie Dortery</b>  |  |   |  |                                   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Florence P. Foster</b>  |   |                                  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>263 Westwood Avenue, Apt. 6-A, Staten Island, NY 1031</b>                                |  |   |  |                                   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Calverton National Cemetery</b>   |   |  | Date<br><b>5-14-99</b>                         |   | 20c. Location - City or Town, State<br><b>Calverton, New York</b>                              |                                   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>R. Noel Brady</b>  |   |                                  |  |   | 22. Name and Address of Facility<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 East Antietam Street, Hagerstown, Md. 21740</b>   |  |   |  |                                   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SEPTICEMIA</b><br>Due to (or as a consequence of):<br><b>b. Pneumonia</b><br>Due to (or as a consequence of):<br><b>c. metabolic Encephalopathy</b><br>Due to (or as a consequence of):<br><b>d. Liver cirrhosis</b> |   |                                  |  |   |  |  |   |  |                                   | Approximate Interval Between Onset and Death<br><b>1 wk</b><br><b>1 wk</b><br><b>unknown</b><br><b>unknown</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b><br><b>Coronary artery Disease</b><br><b>Diabetes mellitus</b>   |   |                                  |  |   |  |  |   |  |                                   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                  |  |   |  |  |   |  |                                   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                                  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |   |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                                  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |   |  | 29c. License number<br><b>044996</b>           |   | 29d. Date signed (Month, Day, Year)<br><b>May 8, 1999</b>                                      |                                   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Zafar Malik MD 20311 Lappans Rd Annapolis MD 21713</b>  |   |                                  |  |   |  |  |   |  |                                   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 11 1999</b>  |   |                                  | 32. Registrar's Signature<br><b>[Signature]</b>  |   |  |  |   |  |                                   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Foster, John  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16459

|  |  |   |  |  |  |   |   |  |
|--|--|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Bettie Jayne Fiorani</i>  |   |  |  | 2. Date of Death<br>Month <i>05</i> Day <i>05</i> Year <i>99</i> |   | 3. Time of Death<br><i>7:10 p.m.</i>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Carroll Lutheran Village Health Care Center Westminster</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Carroll</i>           |   | 4c. County of Death<br><i>Carroll</i>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>212-22-4591</i>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><i>72</i> Yrs.                 |   | 8. Date of Birth (Month, Day, Year)<br><i>Sept. 2, 1926</i> |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>MD.</i>   |   | 10e. State<br><i>MD.</i>   |  | 10b. County<br><i>Carroll</i>                                    |   | 10c. City, Town or Location<br><i>Westminster</i>           |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><i>300 St. Luke Circle</i>  |  | 10f. Zip Code<br><i>21158</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>9</i> College (1-4or 5+) <i>Production</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Production</i>                    |  | 16b. Kind of Business/Industry<br><i>Maryland Cup</i>  |  | 17. Father's Name (First, Middle, Last)<br><i>Ernest Gosnell</i>  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Birdie Wagner</i>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Bettie Townsend/daughter</i>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2930 Schoolhouse Lane, Taneytown, MD 21787</i>   |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Carroll Cremation, Inc.</i>   |  | 20c. Location - City or Town, State<br><i>5-11-99 Hampstead, MD 21074</i>   |  | 21. Signature of Funeral Service Licensee<br><i>John K. Arley</i>  |  | 22. Name and Address of Facility<br><i>Pitts Funeral Home &amp; Chapel<br/>412 Washington Road<br/>Westminster, MD.</i>   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><i>Dementia Alzheimer Type</i><br>Due to (or as a consequence of):<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>Cardiac</i> |  | Approximate Interval Between Onset and Death<br><i>Years</i>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   |  |
| 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>J.H. Corcoran MD</i>  |   |  |
| 29c. License number<br><i>D 00906</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>5/05/99</i>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>J.H. Corcoran MD P.O. Box 110 Union Bridge MD 21787</i>   |  | 31. Date filed (Month, Day, Year)<br><i>MAY 10 1999</i>   |   |  |
| 32. Registrar's Signature<br><i>Geneva B. Sparks</i>   |  |   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16460

|  |  |   |  |   |  |  |  |  |
|--|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Mark William Fleming</b>                            |   |  |   | 2. Date of Death<br>Month <b>May</b> Day <b>4</b> Year <b>99</b> |  | 3. Time of Death<br><b>8:25pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Northwest Hospital Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Randallstown</b>      |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-14-3110</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>April 16, 1922</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |  |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Carroll</b>   |  | 10c. City, Town or Location<br><b>Woodbine</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2111 Gillis Falls Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21797</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/><br><b>3years</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Veterans Administration</b>   |  |  | 16b. Kind of Business/Industry<br><b>Chief Appraiser</b>                                       |  |
| 17. Father's Name (First, Middle, Last)<br><b>John B. Fleming</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Amy Leatherwood</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gaye L. Grimes (daughter)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5312 Fleming Rd. Mount Airy, MD 21771</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Morgan Chapel Cemetery</b>   |  | Date<br><b>5/7/99</b>  |  | 20c. Location - City or Town, State<br><b>Woodbine, MD</b>   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Burrier-Queen Funeral Directors, P.A.<br/>1212 West Old Liberty Rd. Winfield, MD 21784</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Congestive heart failure</b><br>Due to (or as a consequence of):<br>b. <b>Atherosclerotic heart disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |   |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |  |   |  | 28d. Describe how injury occurred   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)         |  |
|  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D46263</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>May 4 99</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AYMAN YOUSSEFI MD</b> <b>5401 Old Court Rd, Randallstown MD 21133</b>   |  |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 06 1999</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16461

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>THOMAS WILLIAM FENWICK, JR.</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>MAY 6, 1999</b>   |  | 3. Time of Death<br><b>12:20 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>559 MUNROE CIRCLE</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-26-0708</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 9, 1930</b>                          |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ANNE ARUNDEL</b>   |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>                                    |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>559 MUNROE CIRCLE</b>  |  | 10f. Zip Code<br><b>21061</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SUPERVISOR</b>                        |  | 16b. Kind of Business/Industry<br><b>PEPSI COLA</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>THOMAS W. FENWICK, SR.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LAUREEN ELLIOTT</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>IRIS J. FENWICK (WIFE)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>559 MUNROE CIRCLE, GLEN BURNIE, MD. 21061</b>  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>   |  | 20c. Date<br><b>5/8/99</b>   |  | 20d. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b>                       |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>End Stage Chronic Pulmonary Obstructive Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>46816</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>5/6/99</b>                                 |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anil Chopra, MD 7575 Ritchie Hwy. Glen Burnie, Md 21061</b>   |  |   |  |  |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>  |  |   |  | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

MAY 1 1933



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louise Adina Fearon

2. Date of Death

Month

Day

Year

may 01 1999

0620

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville MD

4c. County of Death

Montgomery

5. Social Security Number

180-78-2480

6. Sex

1 M

2 F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 8, 1908

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Darnestown

10d. Inside City Limits

1 Yes 2 No X

10e. Street and Number

14844 Poplar Hill Road

10f. Zip Code

20874

10g. Citizen of What Country?

Jamaica

11. Marital Status

1 Never Married

2 Married

3 Widowed

4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

College

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Samuel Fearon

18. Mother's Name (First, Middle, Maiden Surname)

Adina Fearon

19a. Informant's Name/Relationship (Type, Print)

Masie M. Neufville (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14844 Poplar hill Rd. Darnestown, Md 20874

20a. Method of Disposition

1 Burial

2 Cremation

3 Removal from State

4 Donation

5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Family Cemetery

Date

5-15-99 Clarendon, Jamaica

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Snead Mortuary Service P.O. Box 5804 Capitol Heights, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Failure

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Months

Days

Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

3 Probably

4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 Outpatient

3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

036979

29d. Date signed (Month, Day, Year)

May 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Deborah Sherrill ms 9901 medical center Dr. Rockville, md.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

*[Signature]*

20850

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MAY 03 1999





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16463

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Frances Ford

2. Date of Death

Month Day Year  
APRIL 30 1999

3. Time of Death

7:42 AM

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

213-22-3315

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 26, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16401 Arywood Lane

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Christan Mill Frey

18. Mother's Name (First, Middle, Maiden Surname)

Frances Jenkins

19a. Informant's Name/Relationship (Type, Print)

Frederick K. Ford, Jr. - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16401 Arywood Lane, Bowie, Maryland 20716

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

05/02/99

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

W. B. Gerson

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Myocardial Infarction

Approximate Interval Between Onset and Death

"hours"

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Multiple Sclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

David Granite MD

29c. License number

D17572

29d. Date signed (Month, Day, Year)

5/1/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

David Granite MD 115 centerway Greenbelt, MD 20770

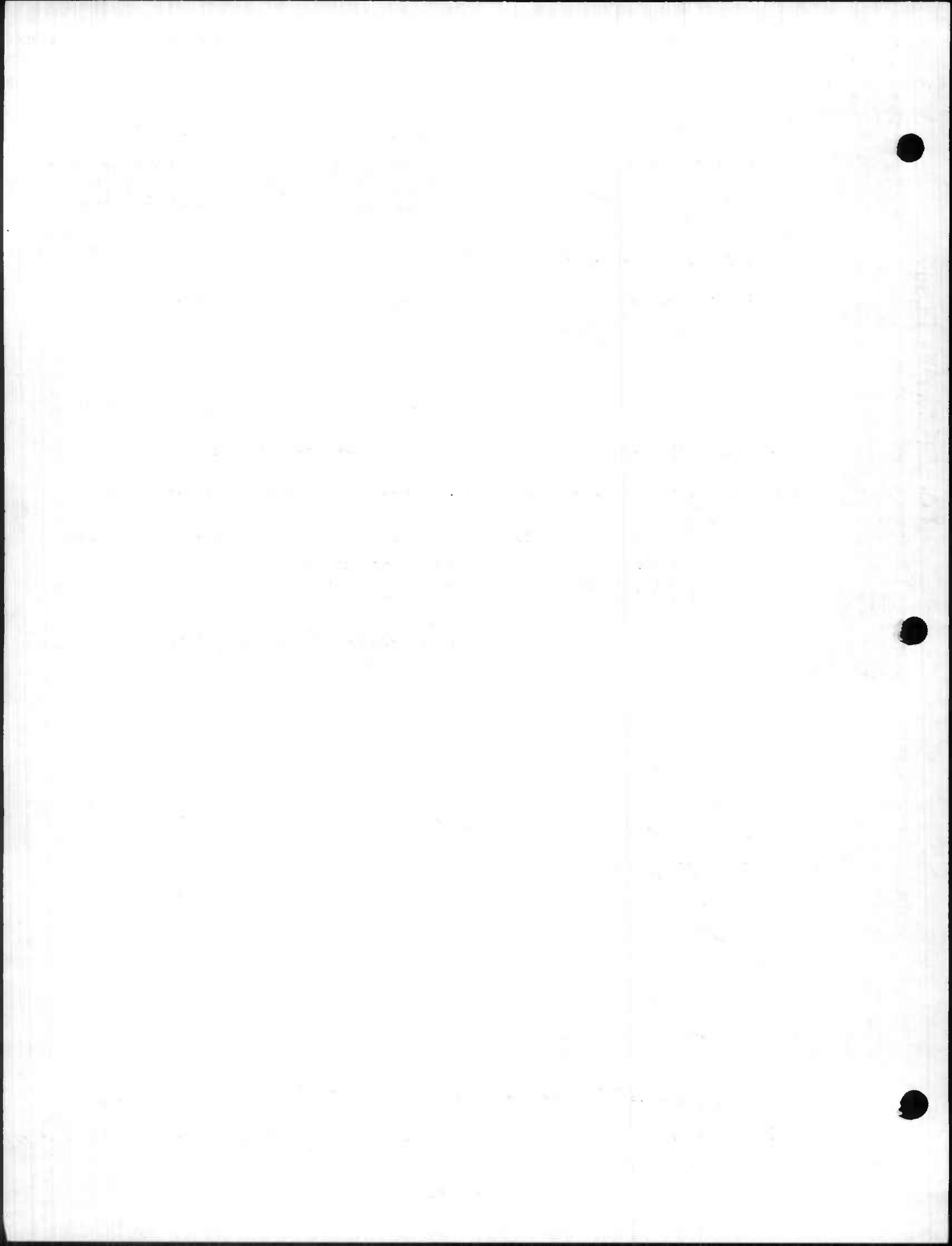
31. Date filed (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

Benjamin A. Sparks

State  
Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16464

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert W. Frankenfield

2. Date of Death

Month Day Year  
May 3, 1999

3. Time of Death

1:10 P.M.

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-24-2743

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 28, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17610 Central Avenue

10f. Zip Code

20716

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates: 1946-48

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Insurance Adjuster

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Robert DeWitt Frankenfield

18. Mother's Name (First, Middle, Maiden Surname)

Lulu E. Rhineheimer

19a. Informant's Name/Relationship (Type, Print)

Steven J. Frankenfield/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17610 Central Ave. Bowie, MD 20716

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Oxford Cemetery

Date

5/7/99

20c. Location - City or Town, State

New Oxford, PA.

21. Signature of Funeral Service Licensee

*George P. Kalas*

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.

2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Septic*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*1 Week*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Peritonitis*  
Due to (or as a consequence of):

*1 Week*

c. *Eschemic Mt. Colon*  
Due to (or as a consequence of):

*1 Week*

d. *Coronary Vascular Disease*

*Yrs*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*steroid Dependent C.O.P.D*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*H. Hunter*

29c. License number

*007850*

29d. Date signed (Month, Day, Year)

*May 3, 1999*

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

*H.L. MARTER, 7610 Central Ave, Takoma Park, 20716*

31. Date filed (Month, Day, Year)

*MAY 05 1999*

32. Registrar's Signature

*B. Sparks*

State  
Registrar

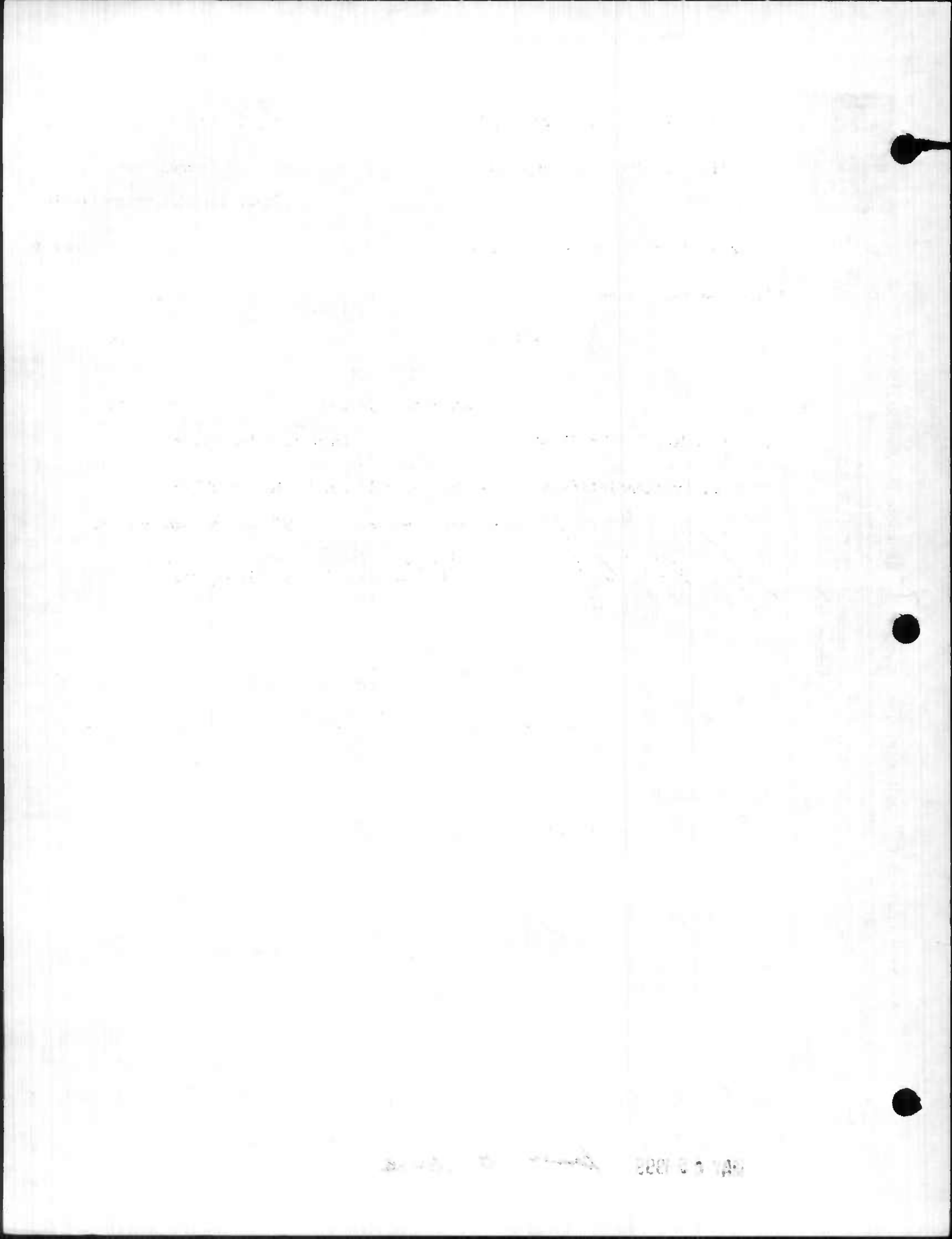
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

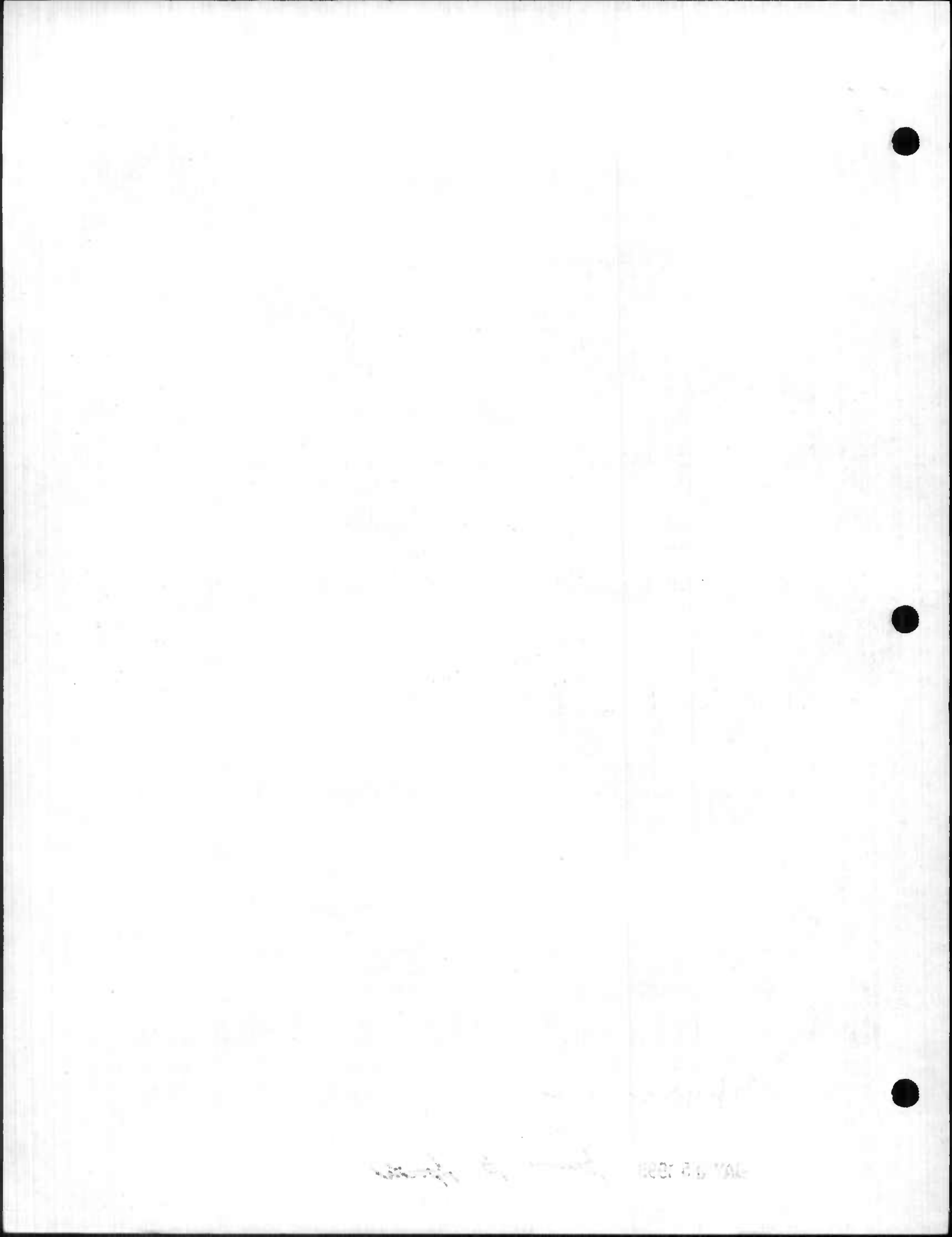
State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16465

|  |  |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ANNIE MAE FORREST</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 30, 1999</b>   |  | 3. Time of Death<br><b>10:56 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-60-2477</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 26, 1918</b>                          |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Beaufort, S.C.</b>  |  | 10a. State<br><b>D.C.</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Washington</b>                                     |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>4406 Kansas Ave., N.W.</b>   |  | 10f. Zip Code<br><b>20011</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>File Clerk</b>  |  | 16b. Kind of Business/Industry<br><b>Dept. of Navy</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Elliott Dinkins</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nora Dinkins</b>  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lamon Forrest - Husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4406 Kansas Ave. N.W., Washington, DC 20011</b>   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | Date<br><b>5-6-99</b>   |  | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>                          |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street N.W. Washington, DC 20011</b>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b. <b>Urinary Tract Infection</b><br>Due to (or as a consequence of):<br><br>c. <b>Dehydration</b><br>Due to (or as a consequence of):<br><br>d. |  |   |  |   |  |  |  |
|  | Approximate Interval Between Onset and Death<br><br><b>Sudden</b><br><br><b>Days</b><br><br><b>Days</b>  |  |   |  |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Gastrointestinal Bleeding</b>   |  |   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
|  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D-32332</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>04/30/99</b>  |  |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>S. K. Gupta, M.D. 9801 Georgia Ave., Silver Spring, MD</b>  |  |   |  |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>MAY 05 1999</b>  |  | 32. Registrar's Signature<br>   |  |   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>TERESA E. FARMER  |  |   |  | 2. Date of Death<br>Month 05 Day 05 Year 99  |  |  |  | 3. Time of Death<br>10:20 am                                     |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>3502 Hubbard Road, #203   |  |   |  | 4b. City, Town, or Location of Death<br>Landover   |  |  |  | 4c. County of Death<br>Prince George's                           |  |
| Funeral<br>Director                           | 5. Social Security Number<br>578-54-9053  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>57 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>October 17, 1941  |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.     |  |
|   | Usual Residence of Decedent   |  |   |  | 10a. State<br>Maryland   |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Landover                          |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Landover  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
|   | 10e. Street and Number<br>3502 Hubbard Road, #203   |  |   |  | 10f. Zip Code<br>20785   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+) College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>House Wife                               |  | 16b. Kind of Business/Industry<br>Private  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>Daniel Wright  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Della Harris  |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Terri Lonon/Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9018 Taylor Street, Springdale, Maryland 20774  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cemetery   |  | Date<br>05/13 1999   |  | 20c. Location - City or Town, State<br>Arlington, Virginia   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Belva J. Jenkins</i>  |  |   |  | 22. Name and Address of Facility<br>J.B. JENKINS FUNERAL HOME<br>7474 Landover Road, Landover, Maryland 20785  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>congestive heart failure</i><br>Due to (or as a consequence of):<br>b. <i>Anemia</i><br>Due to (or as a consequence of):<br>c. <i>Diabetes Mellitus</i><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>XIS<br>Months<br>XIS.  |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                                |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><i>Belva J. Jenkins</i>  |  | 29c. License number<br>D41978  |  | 29d. Date signed (Month, Day, Year)<br>5-6-99  |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>N. Iavakoli PAH Chevy MD 20785  |  |   |  |  |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>MAY 07 1999  |  |   |  | 32. Registrar's Signature<br><i>Belva J. Jenkins</i>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16467

ITEMS: #23 PART I, II, 27 PER MEO G771 5-26-99 WR.

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Harold P. Grambs</b>  |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>12</b> , Year <b>1999</b>   |  | 3. Time of Death<br><b>0800 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>8502 49 TH STREET</b>   |  | 4b. City, Town, or Location of Death<br><b>COLLEGE PARK</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| 5. Social Security Number<br><b>541-16-1266</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  |
| 8. If Under 1 Year<br>Months Days  |  | 9. If Under 24 Hrs.<br>Hours Min.   |  | 6. Date of Birth (Month, Day, Year)<br><b>April 21, 1917</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>China</b>   |  |   |  |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>College Park</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 10e. Street and Number<br><b>8502 49th Avenue</b>  |  | 10f. Zip Code<br><b>20740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Personnel Manager</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. Department of Agriculture</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harold Willis Grambs</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mattie Bostick</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronald Willoner - Personal Rep.</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4603 Calvert Road, College Park, Maryland 20740</b>   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |  |
| 20d. Date<br><b>05/18/99</b>   |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>W.B. Grambs</b>  |  | 22. Name and Address of Facility<br><b>Gasch's Funeral Home</b><br><b>4739 Baltimore Avenue, Hyattsville, MD 20781</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HYPERTENSIVE AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>  |  |   |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>pulmonary emphysema</b>  |  |   |  |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>J. Pestaner, M.D.</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>MAY 13, 1999</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 18 1999</b>  |  | 32. Registrar's Signature<br><b>B. Smith</b>  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16468

## Certificate of Death

Reg. No.

|   |  |                           |   |   |  |                          |  |  |  |  |  |
|---|--|---------------------------|---|---|--|--------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Richard Cecil GROVE                        |                           |   |   | 2. Date of Death<br>Month Day Year<br>May 3, 1999  |                          |  |  | 3. Time of Death<br>9:00 a. m.                       |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>112 W. Howard Street |                           |   |   | 4b. City, Town, or Location of Death<br>Hagerstown   |                          |  |  | 4c. County of Death<br>Washington                    |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>426-14-5017   |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (in yrs. last birthday)<br>85 Yrs.  |                          | 8. Date of Birth (Month, Day, Year)<br>Dec. 26, 1913 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|   | Usual Residence of Decedent  |                           |   |   |  |                          |  |  |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Washington |   | 10c. City, Town or Location<br>Hagerstown   |  |                          |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>112 W. Howard Street  |  |                           |   | 10f. Zip Code<br>21740  |  |                          |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                               |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 0  |  |                           |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>bus boy  |  |                          |  | 16b. Kind of Business/Industry<br>restaurant   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Ralph Cecil Grove  |  |                           |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Jeannette M. Haffner   |  |                          |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>D. Wilbur Haffner - cousin  |  |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>407 Sunny Drive, Waynesboro, Pennsylvania  |  |                          |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Hill Cemetery   |  | Date<br>5-8-99           |  | 20c. Location - City or Town, State<br>Waynesboro, Pa.   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                           |   | 22. Name and Address of Facility<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |  |                          |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                           |   |   |  |                          |  |  |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>Arteriosclerotic Heart Disease   |  |                           |   |   |  |                          |  |  |  | years  |  |
| Due to (or as a consequence of):  |  |                           |   |   |  |                          |  |  |  |  |  |
| Due to (or as a consequence of):  |  |                           |   |   |  |                          |  |  |  |  |  |
| Due to (or as a consequence of):  |  |                           |   |   |  |                          |  |  |  |  |  |
| Due to (or as a consequence of):  |  |                           |   |   |  |                          |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                           |   |   |  |                          |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |  |                           |   |   |  |                          |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |                           |   |   |  |                          |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                           |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |                           |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred  |  |
|   |  |                           |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                           |   |   |  |                          |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                           |   | 29c. License number<br>D01062   |  |                          |  | 29d. Date signed (Month, Day, Year)<br>May 7, 1999   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Edward W. Ditto, III, M. D., 217 W. Washington St., Hagerstown, Md. 21740   |  |                           |   |   |  |                          |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 13 1999  |  |                           |   | 32. Registrar's Signature<br>   |  |                          |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16469

|   |   |   |  |   |   |  |  |  |
|---|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ZOILA LEONOR GONZALEZ</b>                                |   |  |   | 2. Date of Death<br>Month Day Year<br><b>MAY 12, 1999</b> |  | 3. Time of Death<br><b>7:15 P.M.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GENESIS ELDERCARE NURSING HOME</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>LA PLATA</b>   |  | 4c. County of Death<br><b>CHARLES</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-70-8415</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 1, 1912</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>CUBA</b>                              |
|   | Usual Residence of Decedent   |   |  |   |   |  |  |  |
| 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>CHARLES</b>   |  | 10c. City, Town or Location<br><b>LA PLATA</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1 MAGNOLIA DRIVE (GENESIS N.H.)</b>  |   |   |  | 10f. Zip Code<br><b>20646</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: <b>CUBAN</b>   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DIETARY ASSISTANT</b>   |   |  | 16b. Kind of Business/Industry<br><b>MARRIOTT CORP.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>AURELIO RANGEL</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MODESTA DELGADO</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARIA TORRES - NIECE</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3636 YORKTOWN DRIVE WALDORF, MD. 20601</b>  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>COLUMBIA GARDENS CEM</b>   |   | 20c. Location - City or Town, State<br><b>5-14-99 ARLINGTON, VA.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>RAYMOND FUNERAL SERVICE, P.A.<br/>LA PLATA, MARYLAND 20646</b>   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><b>b. Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><b>c. Advanced Osteoarthritis</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  | Approximate Interval Between Cause and Death<br><b>1 year</b><br><b>1 year</b>  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
|   |   |   |  |   |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|   |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury of Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  | 29c. License number<br><b>D20629</b>  |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29d. Date signed (Month, Day, Year)<br><b>5/13/99</b>   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23b) (Type, Print)<br><b>GREGORY D. WATSON WARDORF, MD 20603</b>  |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 13 1999</b>   |   |   |  | 32. Registrar's Signature<br>  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |  |   |
|---|---|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>IVA MAE GANN</b>                                   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>APRIL 24 1999</b> |  | 3. Time of Death<br><b>2:02 PM</b>   |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Laurel Regional Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Laurel</b>      |  | 4c. County of Death<br><b>Prince George's</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>566-12-2223</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.   | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 6, 1904</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Missouri</b>   |
|   | Usual Residence of Decedent   |   |  |  |  |  |  |   |
| 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Laurel</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>81 South Paula Street</b>  |   |   |  | 10f. Zip Code<br><b>20724</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 8</b> Collage (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>James Jackson</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lieu Merrel</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Billy Gann / son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3367 Old Line Avenue Laurel, Maryland 20724</b>  |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | Date<br><b>4/26/99</b>   |  | 20c. Location - City or Town, State<br><b>Catonsville, Md.</b>  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Donaldson Funeral Home, P.A.<br/>313 Talbott Avenue Laurel, Maryland 20707</b>  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. UROSEPSIS</b><br>Due to (or as a consequence of):<br><b>c. ORGANIC BRAIN SYNDROME</b><br>Due to (or as a consequence of):<br><b>d. ATHEROSCLEROSIS</b> |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 WEEK</b><br><b>1 DAY</b><br><b>YEARS</b><br><b>YEARS</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b><br><b>CORONARY ARTERY DISEASE</b><br><b>HYPERTENSION</b>  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                   |
|   |   |   |  | 28d. Describe how injury occurred  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)         |   |
|   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D25422</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>APRIL 25, 1999</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT M. GANN, MD 13952 BALTIMORE AVE., LAUREL, MARYLAND 20707</b>  |   |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>APR 27 1999</b>   |   |   |  | 32. Registrar's Signature<br>  |  |  |  |   |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16471

|  |   |   |  |   |   |  |  |  |
|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>George G. Gawel                                   |   |  |   | 2. Date of Death<br>Month Day Year<br>May 5, 1999 |  | 3. Time of Death<br>21:05                            |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center |   |  |   | 4b. City, Town, or Location of Death<br>Annapolis |  | 4c. County of Death<br>Anne Arundel                  |  |
| Funeral<br>Director  | 5. Social Security Number<br>066-09-0592  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>81 Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br>Oct. 29, 1917 |  |
|  | 9. Birthplace (State or Foreign Country)<br>New York  |   | 10a. State<br>Maryland   |   | 10b. County<br>Anne Arundel                       |  | 10c. City, Town or Location<br>Annapolis             |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br>1105 Lake Heron Drive   |  | 10f. Zip Code<br>21403  |   | 10g. Citizen of What Country?<br>United States                                       |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1941-1945   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>New York Telephone Company   |  | 16b. Kind of Business/Industry<br>Management  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Alfred Gawel  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Betsy Grindrod   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Elinor Smith Gawel/Wife  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1105 Lake Heron Drive Annapolis, MD 21403  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Crematory  |  | 20c. Location - City or Town, State<br>Brentwood, Maryland  |   | 20d. Date<br>5/9/99  |  |  |
| 21. Signature of Funeral Service Licensee<br>Bryan Powell  |   |   |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke of Gloucester St. Annapolis, MD 21401   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Respiratory Arrest<br>Due to (or as a consequence of): COPD<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |   |   |  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |  |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>H.D.G. Heston M.D.  |   | 29c. License number<br>D26743   |  | 29d. Date signed (Month, Day, Year)<br>5/6/99   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>H.D.G. Heston M.D. 205 Ridgely Ave Annapolis   |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 06 1999   |   | 32. Registrar's Signature<br>B. Spahr   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 5 5/11/99 CMH State of Maryland / Department of Health and Mental Hygiene  
AMEND: #9 mcg A.A.CO. HEALTH DEPT

## Certificate of Death

Reg. No.

99 16472

|  |  |  |   |  |  |  |  |   |  |  |
|--|--|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Clarence C. Gaar   |  |   |  | 2. Date of Death<br>Month Day Year<br>May 4 1999   |  |  |   | 3. Time of Death<br>7:00PM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Anne Arundel Medical Center  |  |   |  | 4b. City, Town, or Location of Death<br>Annapolis  |  |  |   | 4c. County of Death<br>Anne Arundel  |  |
| Funeral<br>Director  | 5. Social Security Number<br>437-261-994   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>75 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 22, 1924   |   | 9. Birthplace (State or Foreign Country)<br>Louisiana  |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Md.  |  | 10b. County<br>Anne Arundel   |  | 10c. City, Town or Location<br>Annapolis   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>509 Forest Hill Drive  |  |   |  | 10f. Zip Code<br>21403   |  |  |   | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1941-63  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Communications  |  |  |   | 16b. Kind of Business/Industry<br>Defense  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Eugene F. Gaar  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hazel S. Buckley  |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Reba L. Gaar / wife  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>509 Forest Hill Drive Annapolis, Md. 21403  |  |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lakemont Cemetery  |  | Date<br>5-7-99   |   | 20c. Location - City or Town, State<br>Davidsonville, Md.  |  |
|  | 21. Signature of Funeral Service Licensee<br>C. Brian Powell   |  |   |  | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke of Gloucester St. Annapolis, Md. 21401   |  |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cardiomyopathy</i><br>Due to (or as a consequence of):<br>b. <i>Renal failure</i><br>Due to (or as a consequence of):<br>c. <i>Diabetes Mellitus</i><br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |   |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |   |  |  |
| State Registrar  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Coronary Artery Disease</i>   |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
|  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>Physician   |  |  |   | 29c. License number<br>D47518          |  |  |  | 29d. Date signed (Month, Day, Year)<br>5-5-99 |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Theresa Buckner Anne Franklin Cathedral St. Annapolis, MD 21401  |  |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 06 1999   |  |  |   | 32. Registrar's Signature<br>B. Sparks |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16473

## Certificate of Death

Reg. No.

|   |   |   |  |   |   |   |  |  |  |
|---|---|---|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH BELLE GOLDEN</b>                     |   |  |   | 2. Date of Death<br>Month Day Year<br><b>April 28, 1999</b> |   | 3. Time of Death<br><b>8:45 am</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>8329 Woodward Street</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Savage</b>       |   | 4c. County of Death<br><b>Howard</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-01-6342</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                           | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth (Month, Day, Year)<br><b>May 24, 1913</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent   |   |  |   |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Savage</b>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10a. Street and Number<br><b>8329 Woodward Street</b>   |   |   |  | 10f. Zip Code<br><b>20763</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>        |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Clerk</b>   |   |   | 16b. Kind of Business/Industry<br><b>Private Industry</b>                                      |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>(Unavailable) Thomas</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret A. King</b>  |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Linda F. Beall - Niece</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8329 Woodward Street, Savage, Maryland 20763</b>  |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b> |   | Date<br><b>04/30/99</b>                                     |   | 20c. Location - City or Town, State<br><b>Suitland, Maryland</b>                               |  |  |
| 21. Signature of Funeral Service Licensee<br><b>W.B. Greiner</b>  |   |   |  | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>myocardial infarction</b><br>Due to (or as a consequence of):<br><b>hypertension</b><br>Due to (or as a consequence of):<br><b>coronary artery disease</b><br>Due to (or as a consequence of):<br><b>cerebrovascular disease</b> |   |   |  |   |   |   |  | Approximate Interval Between Onset and Death<br><b>3 hr</b><br><b>10 yr</b><br><b>10 yr</b><br><b>0 yr</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rheumatoid Arthritis</b>   |   |   |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month/Day Year)<br><b>NA</b>   |   | 28b. Time of Injury<br><b>NA</b> M                    |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>NA</b>  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>   |   |   |  | 28d. Describe how injury occurred<br><b>NA</b>  |   |   |  |  |  |
| 28a. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>NA</b>   |   |   |  | 28d. Describe how injury occurred<br><b>NA</b>  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br><b>822</b>   |   |   |  | 29c. License number<br><b>AF 8907480</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>4/28/99</b> |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>S. Falm 7558 Van Duren Rd</b>  |   |   |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 29 1999</b>   |   |   |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



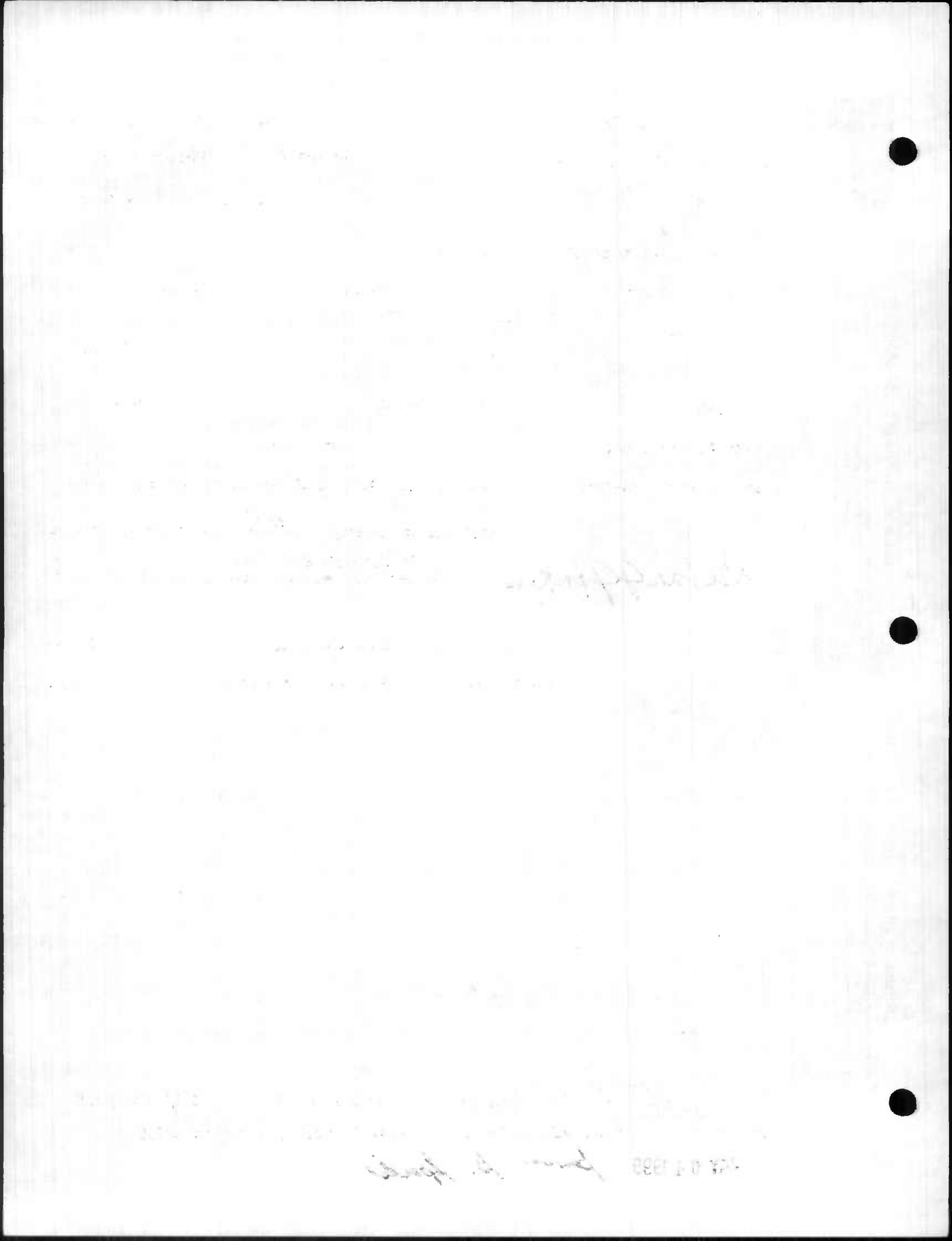
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>ROBERT LEE GRAY, JR.  |  |   |  | 2. Date of Death<br>Month Day Year<br>4 30 99  |  | 3. Time of Death<br>12:20 am   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGE'S HOSPITAL CENTER   |  |   |  | 4b. City, Town, or Location of Death<br>CHEVERLY   |  | 4c. County of Death<br>PRINCE GEORGE'S   |  |
| Funeral<br>Director  | 5. Social Security Number<br>060-36-2289  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>55 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 21, 1944  |  |
|  | 9. Birthplace (State or Foreign Country)<br>New York  |  | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Springdale  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br>9101 Taylor Street  |  | 10f. Zip Code<br>20774   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1963 to 1967  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Metro Bus Driver   |  | 16b. Kind of Business/Industry<br>Private  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Robert L. Gray, Sr.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mamie Brown   |  |  |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Brenda Jarret-Gray/Wife   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9101 Taylor Street, Springdale, Maryland 20774  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery  |  | Date<br>05/05 1999   |  | 20c. Location - City or Town, State<br>Cheltenham, Maryland  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner         | 21. Signature of Funeral Service Licensee<br><i>Betha Jenkins</i>   |  |   |  | 22. Name and Address of Facility<br>J.B. JENKINS FUNERAL HOME<br>7474 Landover Road, Landover, Maryland 20785  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Sun Over Heat Hemorrhage</u><br>Due to (or as a consequence of):<br>b. <u>END STAGE RENAL DISEASE</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>5 days<br>3 years  |  |  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| State Registrar  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| 2  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 2  | 29b. Signature and title of certifier<br><i>Samuel C. Wilson</i>  |  |   |  | 29c. License number<br>D38965  |  | 29d. Date signed (Month, Day, Year)<br>04/30/99  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Samuel C. Wilson, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785  |  |   |  |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>MAY 04 1999  |  |   |  | 32. Registrar's Signature<br><i>Barbara B. Apatis</i>  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16475

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Robert

Grosselfinger

2. Date of Death

Month Day Year  
April 30, 1999

3. Time of Death

1:30AM

4a. Facility Name (If not institution, give street and number)

6202 Stardust Lane

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

050-14-4951

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Month Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 1, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda, Maryland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6202 Stardust Lane

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Aeronautical Engineer

16b. Kind of Business/Industry

US. Government

17. Father's Name (First, Middle, Last)

Frederick Grosselfinger

18. Mother's Name (First, Middle, Maiden Surname)

Ella Guertler

19a. Informant's Name/Relationship (Type, Print)

Elfrieda GrosselfingerWife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6202 Stardust Ln. Bethesda, MD. 20817

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Quantico National

Date

5-4-99

20c. Location - City or Town, State

Quantico, VA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons

5130 Wisconsin Ave. NW. Wash. DC.20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Adenocarcinoma Of Pancreas

14 Mo.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Frederick G. Barr MD

29c. License number

D22775

29d. Date signed (Month, Day, Year)

4-30-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick G. Barr MD. 5454 Wisconsin Ave. Chevy Chase, Md. 20815

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

B. Barr

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

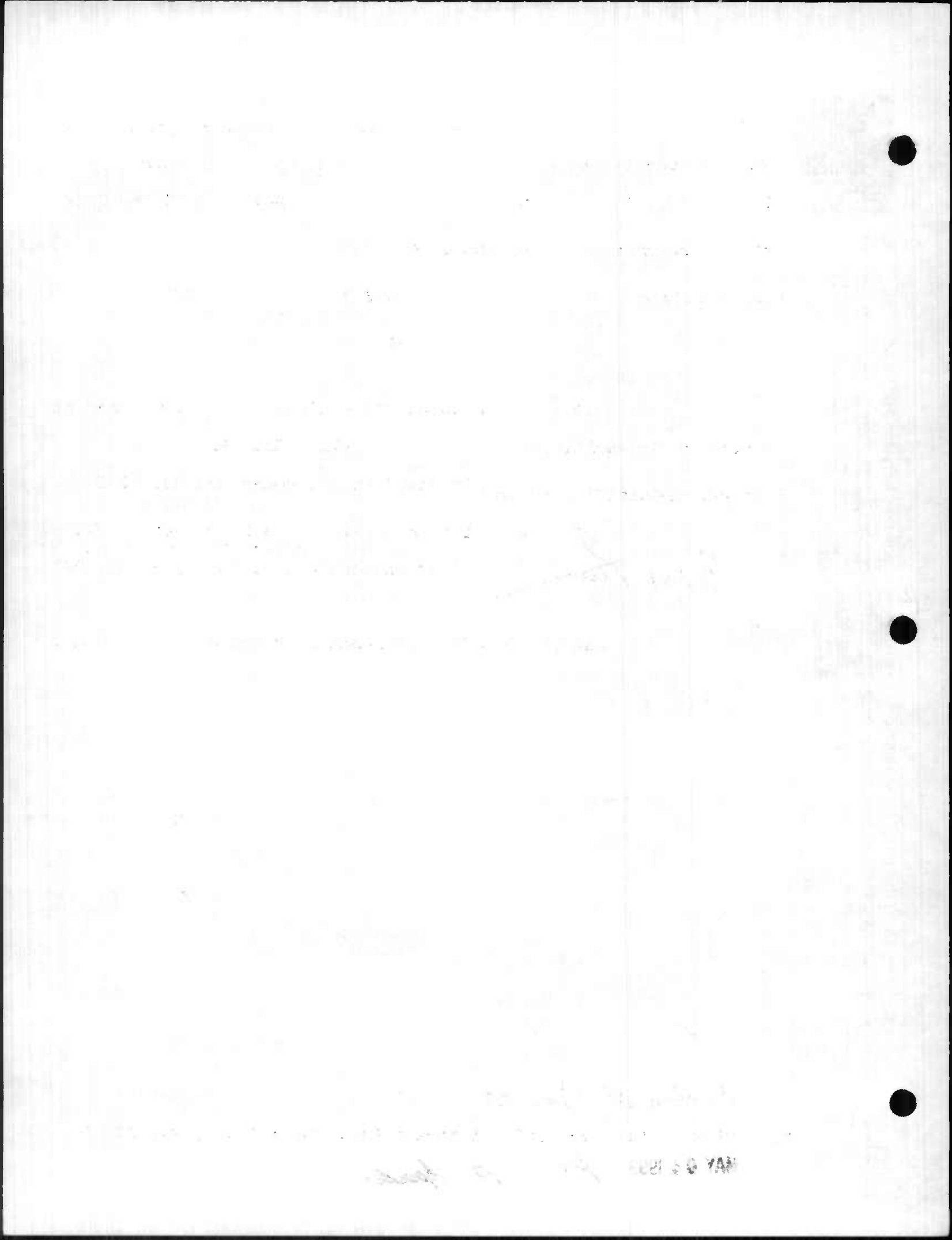
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

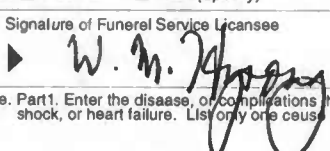
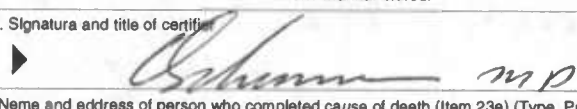

99 16476

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>MILLARD L. GRAY</b>  |  |   |  | 2. Date of Death<br>Month <b>MAY</b> 3, 1999<br>Day<br>Year  |  | 3. Time of Death<br><b>12:10 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL LUTHERAN HOME</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |  | 4c. County of Death<br><b>MONTGOMERY CO.</b>  |  |
| 5. Social Security Number<br><b>221-01-2948</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 29, 1909</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>DELAWARE</b>   |  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>MONTGOMERY</b>   |  | 10c. City, Town or Location<br><b>ROCKVILLE</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>9701- VEIRS DRIVE</b>  |  | 10f. Zip Code<br><b>20850</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW 2</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FIREMAN &amp; SECURITY GUARD- SAFETY</b>      |  | 16b. Kind of Business/Industry   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>THOMAS SMITH GRAY</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELSIE BEHRINGER</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>REV. DR. RICHARD REICHARD-EXECUTOR-9701- VEIRS DR., ROCKVILLE, MD. 20850</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GRACELAWN MEM. PK.</b>   |  | 20c. Date<br><b>5/7/99</b>   |  | 20d. Location - City or Town, State<br><b>NEW CASTLE, DEL.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>HYSONG CO., INC.<br/>1300- N ST., NW, WASH., DC</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <u>Renal Insufficiency</u><br>Due to (or as a consequence of):<br><br>b. <u>Hypertensive renal disease</u><br>Due to (or as a consequence of):<br><br>c. <u>Hypertensive Cardiomyopathy</u><br>Due to (or as a consequence of):<br><br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><br>1 year<br>5 year<br>20 year  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><u>Alzheimer's Dementia, Chronic idiopathic</u><br><u>thrombocytopenia, Splenectomy,</u><br><u>Chronic Venous Insufficiency, Prostate hypertrophy</u>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 36618</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>May 3, 1999</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. CHRISTOPHER SCHEMM - 9701- VEIRS DR., ROCKVILLE, MD.</b>   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 05 1999</b>   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16477

## Certificate of Death

Reg. No.

|   |   |                               |   |  |  |                          |  |  |   |  |  |
|---|---|-------------------------------|---|--|--|--------------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SARAH MAGRUDER HENDERSON</b>                     |                               |   |  | 2. Date of Death<br>Month Day Year<br><b>MAY 10, 1999</b>  |                          |  |  | 3. Time of Death<br><b>1:06 AM</b>                          |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CIVISTA MEDICAL CENTER</b> |                               |   |  | 4b. City, Town, or Location of Death<br><b>LAPLATA</b>   |                          |  |  | 4c. County of Death<br><b>CHARLES</b>                       |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-32-8988</b>   |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.   |                          | 8. Date of Birth (Month, Day, Year)<br><b>AUGUST 4, 1921</b>                                       |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |  |
|   | Usual Residence of Decedent   |                               |   |  | 10c. City, Town or Location<br><b>INDIAN HEAD</b>  |                          | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |  |
| 10e. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>CHARLES</b> |   | 10f. Zip Code<br><b>20640</b>  |  |                          |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)   |   |                               |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BOOKKEEPER</b> |  |                          |  | 16b. Kind of Business/Industry<br><b>AUTOMOTIVE GARAGE</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>LELAND EDELEN</b>   |   |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH MAGRUDER EDELEN</b>  |                          |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>RAYMOND M. HENDERSON/SON</b>   |   |                               |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>700 EDELEN COURT, ACCOKEEK, MARYLAND 20607</b>   |                          |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEMORIAL GARDENS</b>   |  |  | Date<br><b>5/13/1999</b> |  | 20c. Location - City or Town, State<br><b>WALDORF, MARYLAND</b>  |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>JOHN P. KNISLEY</b> M01164  |   |                               |   |  | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156</b>   |                          |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>b. <b>cerebral vascular accident</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |   |                               |   |  |  |                          |  |  |   | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                               |   |  |  |                          |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |  |
|   |   |                               |   |  |  |                          |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |
|   |   |                               |   |  |  |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                          |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |                          | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                           |  |  |
|   |   |                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                               |   |  |  |                          |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |                               |   |  | 29c. License number<br><b>D-22574</b>  |                          |  | 29d. Date signed (Month, Day, Year)<br><b>5/10/99</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Robert T. Pace, MD 12070 Old Line Center Suite 202 Waldorf, Maryland 20602</b>   |   |                               |   |  |  |                          |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 13 1999</b>   |   |                               | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |                          |  |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Sarah Henderson  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16478

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA HARRISON

2. Date of Death

4 28 99 1pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

214-36-2006

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

January 23, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

PRince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8106 Martin Luther King Jr. Hwy. Apt. #614

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

William Benjamin Franklin

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Holland

19a. Informant's Name/Relationship (Type, Print)

Mary Theresa Thompson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1511 Warren Avenue Landover, Maryland 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cemetery

Date

5/3/99

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rollins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

myocardial ischemia

Atrial fibrillation

Pancreatitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43662

29d. Date signed (Month, Day, Year)

5/28/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

William Boyce, M.D. 3001 Hospital Drive Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16479

|  |  |   |   |  |  |  |  |  |
|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Arnold Norman Hull                               |   |   |  | 2. Date of Death<br>Month Day Year<br>May 11 1999  |  | 3. Time of Death<br>1515   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital |   |   |  | 4b. City, Town, or Location of Death<br>Hagerstown |  | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director  | 5. Social Security Number<br>212-14-6086   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79   | If Under 1 Year<br>Months Days                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>April 15, 1920  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   |   |  |  |  |  |  |
| Usual Residence of Decedent  |  |   |   |  |  |  |  |  |
| 10a. State<br>Florida  |  | 10b. County<br>Brevard  |   | 10c. City, Town or Location<br>Titusville  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br>1570 E. Powder Horn Road   |  |   |   | 10f. Zip Code<br>32796   |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW2 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+) 8  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>conductor   |  |  | 16b. Kind of Business/Industry<br>Western Maryland Railroad                                    |  |
| 17. Father's Name (First, Middle, Last)<br>Clarence Blair Hull   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lottie Bell Shank Seaman  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Marie I. Hull  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1570 E. Powder Horn Road Titusville, Florida 32796  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Smithsburg Crematory  |  | Date<br>5/12/99                                    |  | 20c. Location - City or Town, State<br>Smithsburg, Maryland                                    |  |
| 21. Signature of Funeral Service Licensee<br>Gerald N. Minnich   |  |   |   | 22. Name and Address of Facility<br>Gerald N. Minnich 305 N. Potomac Street<br>Funeral Home Hagerstown, Maryland 21740   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Respiratory Failure / Renal Failure Due to (or as a consequence of): 10 days.<br>b. Carcinoma of Bladder Due to (or as a consequence of): 6 mos.<br>c. Cerebral Vascular Accident Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { |  |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Carcinoma lung<br>cholecystitis  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M                           |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28d. Describe how injury occurred  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>Hugh J. Dalton, MD  |  |   |   | 29c. License number<br>D 19755   |  | 29d. Date signed (Month, Day, Year)<br>5-13-99   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>11110 Medical Campus Rd. Hagerstown, MD. 21740 Dr. Dalton  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 13 1999   |  |   | 32. Registrar's Signature<br>B. Sparks  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16480

## Certificate of Death

Reg. No.

|   |   |   |   |  |   |   |  |  |  |
|---|---|---|---|--|---|---|--|--|--|
| Physician<br>(Medical Examiner)   | 1. Decedent's Name (First, Middle, Last)<br><b>Verda Engst HUNT</b>                             |   |   |  | 2. Date of Death<br>Month Day Year<br><b>May 5, 1999</b>  |   | 3. Time of Death<br><b>11:30 a.m.</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Clearview Nursing Home</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Hagerstown</b> |   | 4c. County of Death<br><b>Washington</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>138-24-8019</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                        | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.   | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>July 21, 1904</b>  | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>  |  |
|   | Usual Residence of Decedent   |   |   |  |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Washington</b>  |   | 10c. City, Town or Location<br><b>Boonsboro</b>  |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>18332 Manor Church Road</b>  |   |   |   | 10f. Zip Code<br><b>21713</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                            |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>lab work</b>   |   |   | 16b. Kind of Business/Industry<br><b>medical</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fred Engst</b>  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Stoehr</b>  |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bernard L. Hunt - son</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18332 Manor Church Rd., Boonsboro, Md. 21713</b>   |   |   |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b> |  | Date<br><b>5-6-99</b>                                     |   | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>                                 |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>   |   |   |  |  |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Acute Pulmonary Edema</b><br>Due to (or as a consequence of):<br><br>b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><br>c. <b>Arteriosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |  |   |   |  | Approximate Interval Between Onset and Death<br><br>1 hour<br><br>2 weeks<br><br>1 year                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b>  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   |  |   |   |  | 29b. Signature and title of certifier<br> |  |
| 29c. License number<br><b>D07857</b>  |   |   |   | 29d. Date signed (Month, Day, Year)<br><b>05-06-1999</b>   |   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>EDSON MOODY, MD 1190 Mt. AETNA RD. HAGERSTOWN, MD 21740</b>  |   |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>   |   |   |   | 32. Registrar's Signature<br>  |   |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical Examiner)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16481

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Benjamin Franklin HISS  |   |   |  | 2. Date of Death<br>Month Day Year<br>May 6, 1999  |  | 3. Time of Death<br>5:30 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Corsica Hills - Genesis Elder Care  |   |   |  | 4b. City, Town, or Location of Death<br>Centreville  |  | 4c. County of Death<br>Queen Anne's  |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-10-2480  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>84 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>March 2, 1915   |  |
|   | 9. Birthplace (State or Foreign Country)<br>MD  |   | 10. Usual Residence of Decedent<br>10a. State<br>MD   |  | 10b. County<br>Queen Anne's  |  | 10c. City, Town or Location<br>Stevensville  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 10e. Street and Number<br>304 Ellicot Drive   |  | 10f. Zip Code<br>21666   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII. |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Vending Machine Route Driver                   |  | 16b. Kind of Business/Industry<br>Food Service   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Benjamin Edward Hiss   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sara Warner   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>John Hiss - son   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1551 John Brown Road, Queenstown, MD 21658  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MD Veterans Cemetery  |  | Date<br>May 10, 1999   |  | 20c. Location - City or Town, State<br>Crownsville, Maryland   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Chad H. Hefner</i>  |   |   |  | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>106 Shamrock Road, Chester, MD 21619  |  |  |  |
|   | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)<br/>           a. <u>coronary artery disease</u><br/>           Due to (or as a consequence of):<br/>           b. <u>chronic obstructive pulmonary disease</u><br/>           Due to (or as a consequence of):<br/>           c. <u>congestive heart failure</u><br/>           Due to (or as a consequence of):<br/>           d. <u>diabetes mellitus</u> </p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p>years</p> <p>years</p> <p>years</p> <p>years</p> </div> </div> |   |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>renal insufficiency</u>  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                 |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Kathleen Hoey</i>   |   | 29c. License number<br>D47627  |  | 29d. Date signed (Month, Day, Year)<br>5.6.99  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Kathleen Hoey, M.D., 2540 Centreville Road, Centreville, MD 21617   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 07 1999  |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16482

|  |  |                             |   |   |  |  |  |  |  |  |  |
|--|--|-----------------------------|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Lois Ruth Ihle Horney                  |                             |   |   |  |  | 2. Date of Death<br>Month Day Year<br>April 28, 1999 |  |  | 3. Time of Death<br>2:15 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>215 Saddler Road |                             |   |   |  |  | 4b. City, Town, or Location of Death<br>Grasonville  |  |  | 4c. County of Death<br>Queen Anne's  |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-22-9414   |                             | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>69 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 14, 1929  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|  | Usual Residence of Decedent  |                             |   |   |  |  |  |  |  |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Queen Anne's |   | 10c. City, Town or Location<br>Grasonville  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 10e. Street and Number<br>215 Saddler Road   |  |                             |   |   |  | 10f. Zip Code<br>21638   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4or 5+)   |  |                             |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker/Daycare  |  |  | 16b. Kind of Business/Industry<br>Self               |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Ihle  |  |                             |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Henrietta M. Schafer  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Conrad F. Horney Sr.   |  |                             |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>215 Saddler Road, Grasonville, MD 21638 |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                             |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesterfield Cemetery   |  | Date<br>May 3, 1999  |  | 20c. Location - City or Town, State<br>Centreville, MD   |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Amory M. Chiew</i>   |  |                             |   |   |  | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>106 Shamrock Road, Chester, MD 21619              |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <i>Lung CA</i><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |  |                             |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                             |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |
|  |  |                             |   |   |  |  |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                             |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |                             |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  |                             |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                             |   |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Dr. J. Spruill</i>   |  |                             |   |   |  | 29c. License number<br>032036  |  | 29d. Date signed (Month, Day, Year)<br>4/30/99   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Gary J. Spruill 2108 N. Donahue Ave. Chester, MD 21619   |  |                             |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>APR 30 1999   |  |                             |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

|   |  |  |  |   |   |  |   |  |
|---|--|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES WINDSOR HASTINGS</b>  |  |  |   | 2. Date of Death<br>Month <b>04</b> Day <b>21</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>0956</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital of Easton</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>Easton</b>   |  | 4c. County of Death<br><b>Talbot</b>                                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-20-0498</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 8, 1925</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |   |   |  |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |  |   |   |  |   |  |
|   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>Queen Anne's</b>   |   | 10c. City, Town or Location<br><b>Queen Anne</b>  |  |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |
|   | 10e. Street and Number<br><b>404 Owens Road</b>  |  |  |   | 10f. Zip Code<br><b>21657</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                     |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b> |   | 16b. Kind of Business/Industry<br><b>Self-employed Farming</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>George Lemuel Hastings, Sr.</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Louise Windsor</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lottie Hastings (Wife)</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>404 Owens Rd., Queen Anne, Md. 21657</b>      |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>East New Market Cemetery</b>                  |   | Date<br><b>April 25, 1999</b>   |  | 20c. Location - City or Town, State<br><b>East New Market, Md</b>       |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |   | 22. Name and Address of Facility<br><b>Fellows, Helfenbein &amp; Newnam Funeral Home<br/>408 S. Liberty St., Centreville, Md.</b>                 |  |   |  |
|   | 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |  |   |   |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac Arrhythmia</b><br>Due to (or as a consequence of):<br>b. <b>Generalized Atherosclerosis</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____  |  |  |  |   |   |  |   | <b>30 min</b><br><br><b>15 yrs</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Type 2 Diabetes</b><br><b>COPD</b><br><b>Rheumatoid Arthritis</b>  |  |  |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown<br><br>24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |  |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. Date of Injury (Month, Day, Year) |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No         |   | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |
| 29a. Certifier (Check only one)<br><b>2</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |   |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |  | 29c. License number<br><b>D26388</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>04-21-1999</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Falkenm 302 Collins Hurlock MD 21643</b>   |  |  |  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>APR 22 1999</b>   |  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16484

|  |  |  |   |  |  |  |   |   |  |  |
|--|--|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Virginia Harman</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>April 25 1999</b>   |  |   |   | 3. Time of Death<br><b>7:30pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>9790 Michaels Way</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>   |  |   |   | 4c. County of Death<br><b>Howard</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-01-7371</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec 11, 1914</b>                                  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Ellicott City</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>9790 Michaels Way</b>   |  |   |  | 10f. Zip Code<br><b>21042</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Eby</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruby Irene Thompson</b>  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas W. Harman/Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>44 Lindsey Mill Rd Dugspur, Virginia 24325</b>   |  |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | 20c. Date<br><b>4-28-99</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>                           |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Sam A. Collins - Witzke</i>  |  |   |  | 22. Name and Address of Facility<br><b>Harry H. Witzke's Family Funeral Home, Inc.<br/>4112 Old Columbia Pike Ellicott City, MD 21043</b>  |  |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Brain tumor</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |   |   |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |   |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |   |  |  |
|  | 29b. Signature and title of certifier<br><i>Dr. [Signature]</i>  |  |   |  | 29c. License number<br><b>D29769</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>April 26, 1999</b>                                |   |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marcelino D. Alvarado 1120 W. Holly Rd Brk. Hts. Ark.</b>   |  |   |  |  |  |   |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>APR 27 1999</b>  |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-16485

|  |   |  |   |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Mildred J. Harroll  |  |   |  | 2. Date of Death<br>Month Day Year<br>April 25 1999  |  |  |  | 3. Time of Death<br>10 <sup>30</sup> PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>3908 Don Mill Court   |  |   |  | 4b. City, Town, or Location of Death<br>Ellicott City  |  |  |  | 4c. County of Death<br>Howard  |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-18-2803  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>44 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Oct 19, 1924                                  |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent   |  |   |  | 10a. State<br>Maryland   |  | 10b. County<br>Howard  |  | 10c. City, Town or Location<br>Ellicott City   |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 10e. Street and Number<br>3908 Don Mill Court  |  | 10f. Zip Code<br>21042   |  | 10g. Citizen of What Country?<br>United States   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Charles B. Jaeger  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Grace Manchey   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Richard Harroll/Husband   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3908 Don Mill Court Ellicott City, MD 21042   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest Vet. Cem.   |  | 20c. Location - City or Town, State<br>4-29-99 Owings Mills, MD  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Shirley Collins-Witzke   |  |   |  | 22. Name and Address of Facility<br>Harry H. Witzke's Family Funeral Home, Inc.<br>4112 Old Columbia Pike Ellicott City, MD 21043  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. amyotrophic lateral sclerosis 1 1/2 years<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>pulmonary emphysema   |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  | 29b. Signature and title of certifier<br>Sarahona  |  |
|  | 29c. License number<br>D 21928  |  | 29d. Date signed (Month, Day, Year)<br>April 26, 1999   |  |  |  |  |  |  |  |
| State<br>Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>LEONEL BARAHONA 3459 St John's Lane Md 21042  |  |   |  | 31. Date filed (Month, Day, Year)<br>APR 27 1999   |  |  |  | 32. Registrar's Signature<br>B. Smith  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16486

|  |  |   |  |  |  |  |   |  |  |
|--|--|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Erma K. Hendrickson                                  |   |  |  | 2. Date of Death<br>Month Day Year<br>May 4 1999 |  | 3. Time of Death<br>8:48am                          |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Howard County General Hospital |   |  |  | 4b. City, Town, or Location of Death<br>Columbia |  | 4c. County of Death<br>Howard                       |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-18-9455   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>74 Yrs.        |  | 8. Date of Birth (Month, Day, Year)<br>Apr 29, 1925 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   | 10a. State<br>Maryland   |  | 10b. County<br>Howard                            |  | 10c. City, Town or Location<br>Ellicott City        |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>8489 Linwood Drive   |  | 10f. Zip Code<br>21043   |   | 10g. Citizen of What Country?<br>United States   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary  |  | 16b. Kind of Business/Industry<br>Dredging Company   |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Arthur W. Wareheim Sr.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katherine Hampel  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>L. Vernon Hendrickson Jr./Spouse   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8489 Linwood Drive Ellicott City, MD 21043  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery   |  | 20c. Date<br>5-7-99  |  | 20d. Location - City or Town, State<br>Baltimore, MD                                 |   |  |  |
| 21. Signature of Funeral Service Licensee<br>Sam A Collins - Witzke  |  |   |  | 22. Name and Address of Facility<br>Harry H. Witzke's Family Funeral Home, Inc.<br>4112 Old Columbia Pike Ellicott City, MD 21043  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Lung Cancer<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |  |  |  |   | Approximate Interval Between Onset and Death<br>3 weeks  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |  |  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>Dr. Knight  |  |   |  | 29c. License number<br>D 41139   |  | 29d. Date signed (Month, Day, Year)<br>May 5 <sup>th</sup> , 1999                    |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CLEMENT B. KNIGHT, 2 Knoll North Drive Columbia, MD 21045  |  |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 06 1999   |  | 32. Registrar's Signature<br>James B. Sparks  |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marjorie E. Hatch

2. Date of Death  
Month Day Year  
May 4 19993. Time of Death  
1:30pm

4a. Facility Name (If not institution, give street and number)

3004 North Ridge Road Apt 207

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

031-07-8647

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 7, 1913

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3004 North Ridge Road Apt 207

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Patrick Forrester

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen McGonagle

19a. Informant's Name/Relationship (Type, Print)

Donna Saffle/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6016 Offshore Green Columbia, MD 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

5-7-99

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Sharon A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.

4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

possible NSAID gastritis, osteoarthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patricia A. Toth MD

29c. License number

D31473

29d. Date signed (Month, Day, Year)

May 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA A. TOTH MD 4565 Hemlock Cove Way Ellicott City MD 21042

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 06 1999

32. Registrar's Signature

Barbara B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille A. Haffner

2. Date of Death

Month Day Year  
April 30, 1999

3. Time of Death

5:15 P.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

Future Care of the Chesapeake

4b. City, Town, or Location of Death

Arnold

4c. County of Death

Anne Arundel

5. Social Security Number

276-05-6561

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 29, 1907

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8793 Cardinal Forest Circle

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Retail Store

17. Father's Name (First, Middle, Last)

Albert Gerstenslager

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Laughbaum

19e. Informant's Name/Relationship (Type, Print)

Katherine H. Bernard/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8793 Cardinal Forest Cir. Laurel, MD 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oakwood Cemetery

Date

5-4-99

20c. Location - City or Town, State

Bucyrus, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home  
2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus type II

Hypertension

Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Delaney MD ATTENDING PHYSICIAN

29c. License number

D-40521

29d. Date signed (Month, Day, Year)

May 1, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR OCHANEY

7845 Oakwood Road Suite 205  
Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

MAY 03 1999

32. Registrar's Signature

B. Smith

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16489

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STUART

D.

HARTER

2. Date of Death

Month

Day

Year

MAY

01

1999

3. Time of Death

1850

4e. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

577-14-0935

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 31, 1917

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1825 Hidden Point Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Executive

16b. Kind of Business/Industry

C&amp;P Telephone

17. Father's Name (First, Middle, Last)

Dr. Leonard L. Harter

18. Mother's Name (First, Middle, Maiden Surname)

Nora Davis

19a. Informant's Name/Relationship (Type, Print)

Jean B. Harter / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1825 Hidden Point Rd. Annapolis, Md. 21401

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Crematory

Date

5-3-99

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

E. Brian Powell

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.

147 Duke of Gloucester St. Annapolis, Md. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 DAY

10 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MEDICAL INTERN

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

MAY 01 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOEN ABEDIN, M.D. TOWER 110, 601 N. WOLFE ST. BALTIMORE, MD 21287

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 04 1999

32. Registrar's Signature

B. Smith

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16490

|  |  |  |  |   |  |  |  |  |
|--|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM M. HENSON JR.</b>                 |  |  |   | 2. Date of Death<br>Month Day Year<br><b>APRIL 28 1999</b> |  | 3. Time of Death<br><b>6:30 pm</b>   |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>2054 GATE DRIVE</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-28-8956</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 28 1930</b>   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |
|  | Usual Residence of Decedent  |  |  |   |  |  |  |  |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>   |  | 10c. City, Town or Location<br><b>ANNAPOLIS</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2054 GATE DRIVE</b>   |  |  |  | 10f. Zip Code<br><b>21401</b>   |  | 10g. Citizen of What Country?<br><b>US</b>   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1951-54</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>0</b>  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECURITY GUARD</b>  |  | 16b. Kind of Business/Industry<br><b>CROWNSVILLE STATE HOSPITAL</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>WILLIAM M. HENSON</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>GERTRUDE GRAY</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARY HENSON (WIFE)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2054 GATE DR. ANNAPOLIS, MD. 21401</b>  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEME.</b>   |  | 20c. Location - City or Town, State<br><b>5/3/99 CROWNSVILLE, MD.</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Larry H. Reese</i>   |  |  |  | 22. Name and Address of Facility<br><b>WM. REESE &amp; SONS MORTUARY, P.A.<br/>821 WEST ST. ANNAPOLIS, MD. 21401</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Colon CA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>4 hrs</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|  |  |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|  |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                            |
|  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier:<br><i>John H. Jackson MD</i>   |  | 29c. License number<br><b>030718</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>4-30-99</b>        |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>John Jackson MD, 2003 Bedeare Key, Annapolis, Md 21401</b>  |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 04 1999</b>  |  |  |  | 32. Registrar's Signature<br><i>Benjamin H. Sparks</i>  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STEVEN

M.

HRIN

2. Date of Death  
Month Day Year  
MAY 04 1999

3. Time of Death  
11:06PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-78-9487

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

29 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

NOV. 19, 1969

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ODENTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2443 BLUE SPRING COURT, APT. 303

10f. Zip Code

21113

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COMPUTER SCIENCE

16b. Kind of Business/Industry

N.S.A.

17. Father's Name (First, Middle, Last)

STEVEN

MICHAEL

HRIN

18. Mother's Name (First, Middle, Maiden Surname)

DOLORES

JEAN

MERVAY

19a. Informant's Name/Relationship (Type, Print)

STEVEN HRIN

(FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

522 CHALET WEST, MILLERSVILLE, MD. 21108

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LADY OF THE FIELDS CHURCH CEMETERY

Date

5/8/99

20c. Location - City or Town, State

MILLERSVILLE, MD.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,  
1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ADULT RESPIRATORY DISTRESS SYNDROME

1 MONTH

Due to (or as a consequence of):

b. PNEUMOCYSTIS CARINII PNEUMONIA

1 MONTH

Due to (or as a consequence of):

c. Nocardia Pneumonia

1 month

Due to (or as a consequence of):

d. Thyroid

10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

5/5/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marcus McKenzie, MD 2401 W. Belvedere Avenue Baltimore MD 21215

31. Date filed (Month, Day, Year)

MAY 07 1999

32. Registrar's Signature

*[Signature]* B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16492

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |   |   |
|--|---|---|--|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Elsie Evelyn Holt</b>                          |   |  |   | 2. Date of Death<br>Month Day Year<br><b>May 2, 1999</b> |  | 3. Time of Death<br><b>6:00 am</b>                          |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6103 Cheverly Circle</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Cheverly</b>  |  | 4c. County of Death<br><b>Prince George's</b>               |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-34-6009</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 14, 1936</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |
|  | Usual Residence of Decedent   |   |  |   |  |  |   |   |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Cheverly</b>  |  | 10d. Inalde City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |
| 10e. Street and Number<br><b>6103 Cheverly Circle</b>  |   |   |  | 10f. Zip Code<br><b>20785</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerical</b>  |  | 16b. Kind of Business/Industry<br><b>Non Profit Organization</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank A. Hill</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn E. Dolan</b>   |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lucille M. Vendemia - Sister</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6103 Cheverly Circle, Cheverly, Maryland 20785</b>  |  |  |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>05/03/99 Alexandria, Virginia</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A.<br/>4739 Baltimore Avenue, Hyattsville, MD 20781</b>  |  |  |   |   |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   | Approximate Interval Between Onset and Death<br><b>6 months</b>                             |
| 23a. <b>Metastatic Carcinoma of the Pancreas</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):   |   |   |  |   |  |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
|  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|  |   |   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                       |   |   |  | 29b. Signature and title of certifier<br><i>David M. Goldman</i>  |  | 29c. License number<br><b>D04374</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>5/3/99</b>  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David M. Goldman, M.D., 7500 Hanover Parkway, #105, Greenbelt, Maryland 20770</b>   |   |   |  |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>MAY 03 1999</b>  |   |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 16493  
ITEMS: #23 PART I, 27, 28A-F PER MEO G771 5-20-99 WR. **Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **Heather Dawn Hadlett**  
2. Date of Death Month **March** Day **29**, Year **1999** 3. Time of Death **12:00 PM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **1425 Porter Street**  
4b. City, Town, or Location of Death **Fort Detrich** 4c. County of Death **Frederick**

5. Social Security Number **054-64-9262** 8. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **22** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Aug. 23, 1976** 9. Birthplace (State or Foreign Country) **New York**

Usual Residence of Decedent  
10a. State **MD** 10b. County **Frederick** 10c. City, Town or Location **Fort Detrich** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **1425 Porter Street** 10f. Zip Code **21702-5012** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **College 4-5+** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Laboratory Specialist** 16b. Kind of Business/Industry **Army**

17. Father's Name (First, Middle, Last) **Harlen C Hadlett** 18. Mother's Name (First, Middle, Maiden Surname) **Theresa Fissel**

19a. Informant's Name/Relationship (Type, Print) **Reginald Jennings, Sgt.** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **204 Lee Ave Bldg 59 Fort Meyer, MD 22211**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Bay Area Crematory** Date **4/9/99** 20c. Location - City or Town, State **Clearwater, FL**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Pearson Funeral Home**  
**472 N Washington St Falls Church, VA**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) **SUDDEN DEATH ASSOCIATED WITH SEIZURE DISORDER**  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Approximate Interval Between Onset and Death **MINUTES**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
**Clinical history of seizure disorder**

23b. Did tobacco use contribute to the cause of death?  
☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) **N/A** 28b. Time of Injury **N/A** M **N/A** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred **N/A**  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **N/A** 28f. Location (Street and Number or Rural Route Number, City or Town, State) **N/A**

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **D51775** 29d. Date signed (Month, Day, Year) **April 2, 1999**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Jerry D. Spencer, MD 1413 Research Blvd. Bldg. 102, Rockville, MD 20850**

31. Date filed (Month, Day, Year) **MAY 20 1999** 32. Registrar's Signature **[Signature]**

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

11/19/71

11/19/71



WILLIAM  
IVEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>William Harry Ivey   |   |   |  | 2. Date of Death<br>Month Day Year<br>MAY 2, 1999  |  | 3. Time of Death<br>1:12 P.M.                        |
|  | 4a. Facility Name (If not institution, give street and number)<br>METRO.GROVE ROAD & WATKINS MILL ROAD |   |   |  | 4b. City, Town, or Location of Death<br>GERMANTOWN |  | 4c. County of Death<br>MONTGOMERY                    |
| Funeral<br>Director  | 5. Social Security Number<br>220-60-3364   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>48 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>Aug. 14, 1950   | 9. Birthplace (State or Foreign Country)<br>Maryland |
|  | Usual Residence of Decedent  |   |   |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Prince George's  |   | 10c. City, Town or Location<br>Laurel  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>12101 Dove Circle  |  |   |   | 10f. Zip Code<br>20708   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Plumber   |  | 16b. Kind of Business/Industry<br>Self-Employed  |  |
| 17. Father's Name (First, Middle, Last)<br>Foil Ivey   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna Mae Rager  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Karen D. Ivey - Wife   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>608 Elm Avenue, Takoma Park, Maryland 20910   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MD Veterans' Cemetery   |   | Data<br>05/10/99   |  | 20c. Location - City or Town, State<br>Cheltenham, Maryland  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>Gasch's Funeral Home<br>4739 Baltimore Avenue, Hyattsville, MD 20781   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Aspiration of bolus of food<br>Due to (or as a consequence of):<br>b. Complicating Chronic Alcoholism<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) WOODS |   |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day Year)<br>5/2/99 Found   |   | 28b. Time of Injury Found<br>1100 M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred<br>Subject aspirated/inhaled food   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Woods; Between Grove Rd and Watkins Mill Rd; Germantown, MD  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>MAY 3, 1999   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>MAY 06 1999   |  | 32. Registrar's Signature<br>  |   |  |  |  |  |

To Be Completed by Funeral Director

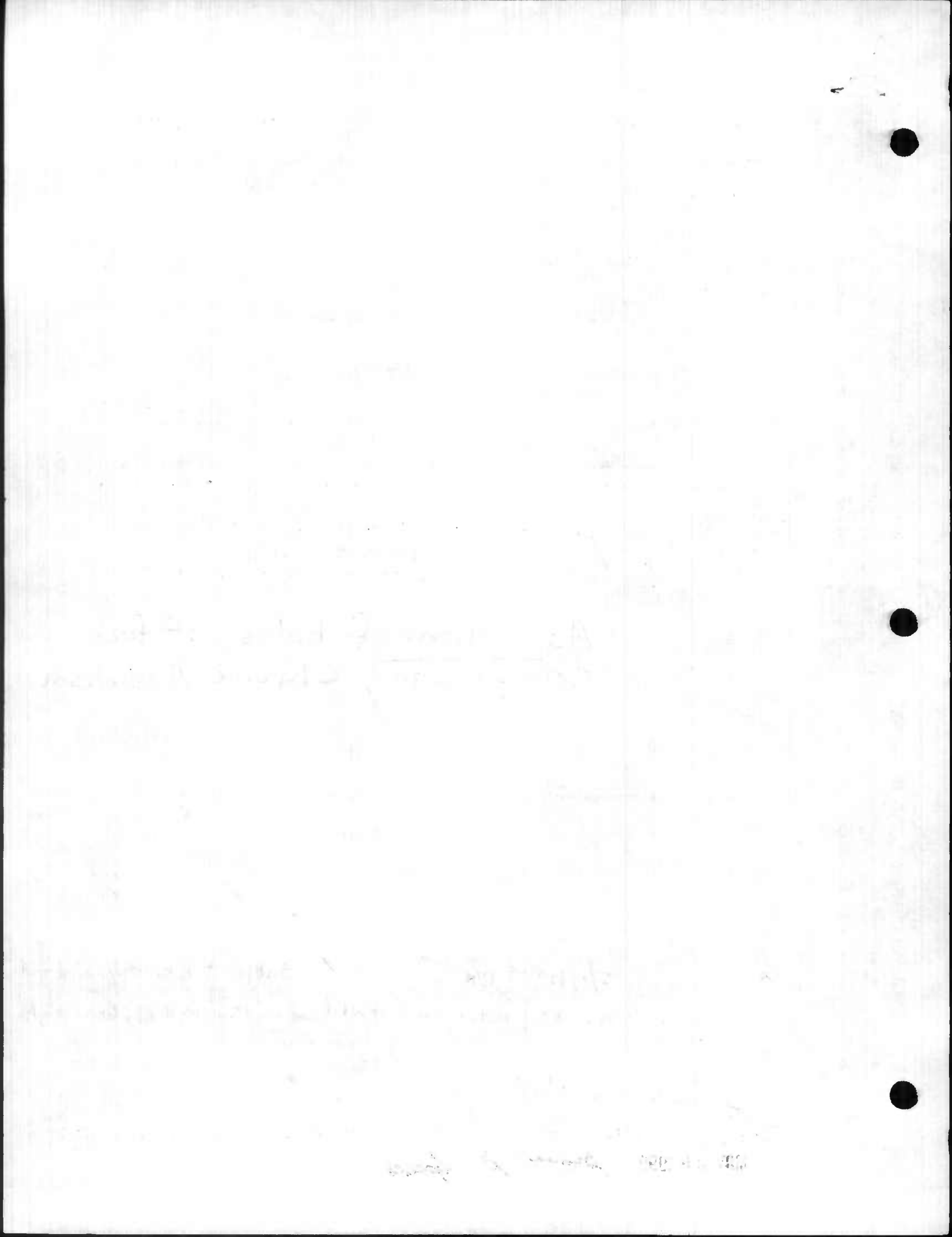
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16495

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY IRELAND

2. Date of Death  
Month Day Year  
April 26 1999

3. Time of Death  
12 noon

4a. Facility Name (If not institution, give street and number)

6220 Q Foreland Garth

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number  
273-28-0843

6. Sex  
1 ☐ M ☒ F

7. Age (In yrs. last birthday)  
66 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
Apr. 11, 1933

9. Birthplace (State or Foreign Country)  
Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6220 Q Foreland Garth

10f. Zip Code

21045

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Grade 12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Jesse Slade Hance

18. Mother's Name (First, Middle, Maiden Surname)

Clara Beale

19a. Informant's Name/Relationship (Type, Print)

Brenda Schluter / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13930 Kennard Drive Glenelg, Maryland 21737

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

4/28/99

20c. Location - City or Town, State

Catonsville, Md.

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Md. 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Skull fracture

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Larynx Cancer

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

"stomach cancer"

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home

5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

Apr 26, 1999

28b. Time of Injury

~ 12 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

fell + hit head

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* Deputy M.D.

29c. License number

D311173

29d. Date signed (Month, Day, Year)

April 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICE A. TOLE MD 4565 Hemlock Lane Way Ellicott City, MD 21042

31. Date filed (Month, Day, Year)

APR 29 1999

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

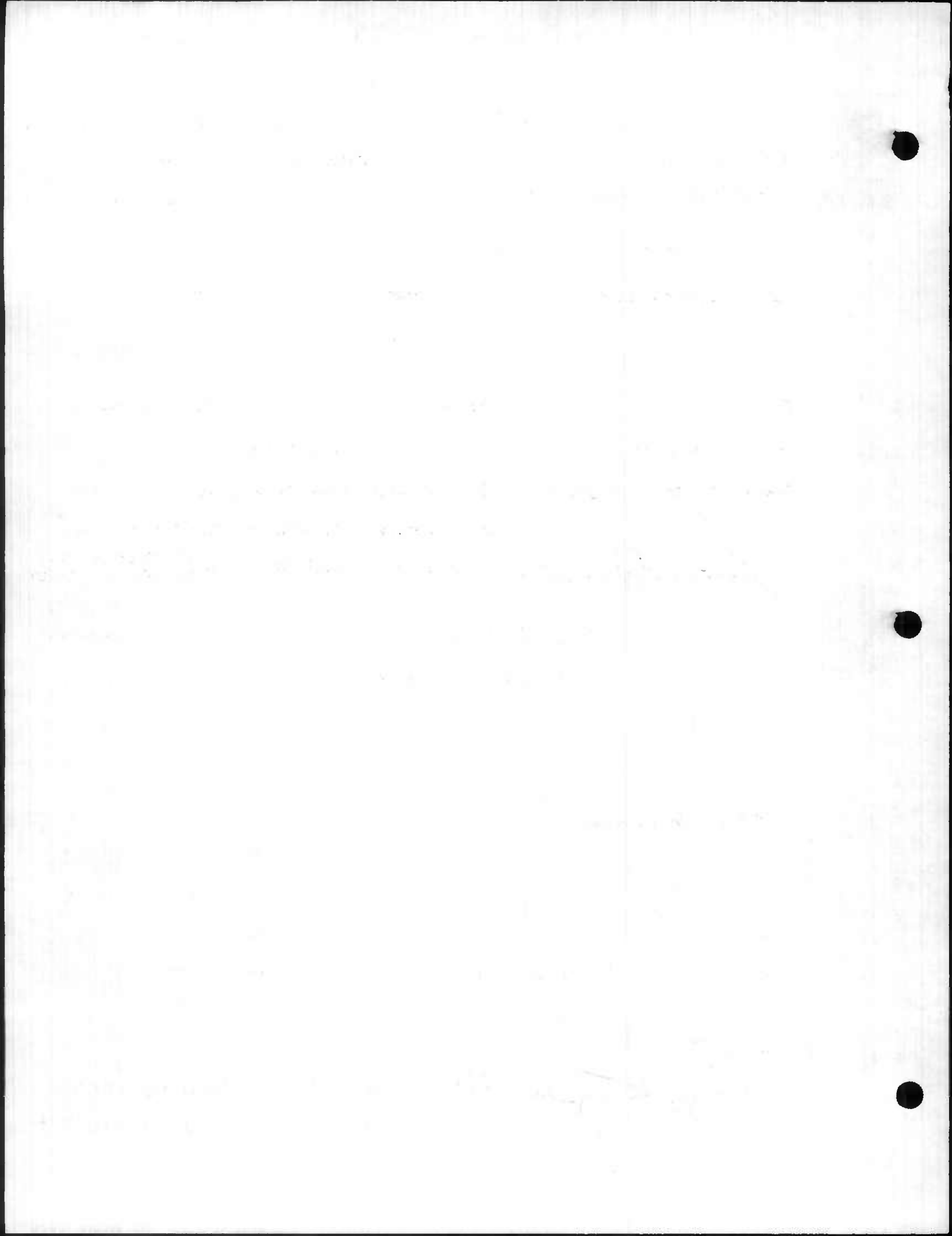
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16496

|   |   |  |  |  |  |   |   |  |
|---|---|--|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thurman D. Jones, Sr.</b>                            |  |  |  | 2. Date of Death<br>Month Day Year<br><b>May 3, 1999</b> |   | 3. Time of Death<br><b>5:02 P.M.</b>                  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>   |   | 4c. County of Death<br><b>Prince George's</b>         |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-44-2461</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.         |   | 8. Date of Birth (Month, Day, Year)<br><b>8/30/34</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Wash., D.C.</b>                                      |  | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>P.G.</b>                               |   | 10c. City, Town or Location<br><b>Seat Pleasant</b>   |  |
| Usual Residence of Decedent   |   |  |  |  |  |   |   |  |
| 10a. State<br><b>Md.</b>  |   |  | 10b. County<br><b>P.G.</b>   |  |  | 10c. City, Town or Location<br><b>Seat Pleasant</b>   |   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  | 10e. Street and Number<br><b>6303 Capon Street</b>   |  |  | 10f. Zip Code<br><b>20743</b>   |   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:       |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) <b>College (1-4or 5+)</b> |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Warehouse Distributor</b>   |   |  | 16b. Kind of Business/Industry<br><b>Safeway Foods</b>   |  |  | 17. Father's Name (First, Middle, Last)<br><b>Phillip Jones</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Sumame)<br><b>Alice Pittman</b>  |   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley T. Jones/Wife</b>   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as # 10 above</b>                              |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cem.</b>   |  |  | 20c. Location - City or Town, State<br><b>Suitland, Md.</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Gary W. Pratt</b>   |   |  | 22. Name and Address of Facility<br><b>H.S. Washington &amp; Sons Co., Inc.<br/>4925 Burroughs Ave., N.E., Wash., D.C. 20019</b>   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |  |  |  |   |   |  |
| <p>Immediate Cause (Final disease or condition resulting in death)</p> <p><b>SEPSIS</b></p> <p>Due to (or as a consequence of):</p> <p><b>MULTIPLE MYELOMA</b></p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p>  |   |  |  |  |  |   |   |  |
| 23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |  |  |  |   |   |  |
| <p><b>ANEMIA</b></p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p>  |   |  |  |  |  |   |   |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |  |  |  |  |   |   |  |
| 23d. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |   |   |  |
| 23e. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |  |  |  |   |   |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>5/3/99</b>   |   |  |  |  |  |   |   |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  |  |  |   |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |  |   |   |  |
| 28d. Describe how injury occurred   |   |  |  |  |  |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  |  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Dr. Venkat S. Ramanan MD</b>  |   |  |  |  |  |   |   |  |
| 29c. License number<br><b>D53885</b>  |   |  |  |  |  |   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>5/5/99</b>  |   |  |  |  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Venkat S. Ramanan 7501 Surratts Road # 307 Clinton MD 20735</b>  |   |  |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 07 1999</b>   |   |  |  |  |  |   |   |  |
| 32. Registrar's Signature<br><b>James B. Smith</b>  |   |  |  |  |  |   |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

99 16497

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUANITA JOHNSON

2. Date of Death

Month  
APRDay  
28Year  
99

3. Time of Death

11:18 AM

4a. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

250-42-6117

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

JAN. 1, 1917

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE

10c. City, Town or Location

FORT WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12200 OLD FORT ROAD

10f. Zip Code

20744

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3RD GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

MACKEY SCOTT

18. Mother's Name (First, Middle, Maiden Surname)

MARY JANE FULTON SCOTT

19a. Informant's Name/Relationship (Type, Print)

SAUNDRA BROWN / GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6010 LANDS END LANE, ALEXANDRIA, VIRGINIA 22315

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESURRECTION CEMETERY

Date

5/3/99

20c. Location - City or Town, State

CLINTON, MARYLAND

21. Signature of Funeral Service Licensee

LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal InsufficiencyPericardial Ussular DiseaseHypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

WILLIAM CLAUER

29c. License number

BG1740097

29d. Date signed (Month, Day, Year)

4/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM CLAUER 61916 OXON HILL RD, SUITE 445 OXON HILL, MD

31. Date filed (Month, Day, Year)

MAY 04 1999

Registrar's Signature

B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



49-10000-1-1

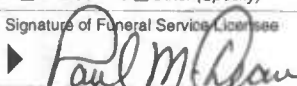


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

09 16498

|   |   |   |   |  |  |  |   |  |
|---|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>IRENE WILHELMENIA JOHNSON</b>  |   |   |  | 2. Date of Death<br>Month <b>MAY</b> Day <b>11</b> Year <b>1999</b>  |  | 3. Time of Death<br><b>8:20 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>5 COLUMBINE DRIVE</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>KEEDYSVILLE</b>   |  | 4c. County of Death<br><b>WASHINGTON</b>  |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>220-64-2038</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 11, 1911</b>                                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |   | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>WASHINGTON</b>   |  | 10c. City, Town or Location<br><b>KEEDYSVILLE</b>   |  |
| To Be Completed by Funeral Director                     | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>5 COLUMBINE DRIVE</b>  |  | 10f. Zip Code<br><b>21756</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ALBERT L. SCHLEIDEN</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EMMA HEUBACH</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>CYNTHIA DRESSEL/DAUGHTER</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5618 OAK PLACE, BETHESDA, MARYLAND 20817</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FAIRVIEW CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>5/15/99 KEEDYSVILLE, MARYLAND</b>  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Paul M. Dean BAST FUNERAL HOME</b>   |  | 7606 Old National Pike<br>Boonsboro, Maryland 21713  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>pancreatic carcinoma</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death or resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b><br><b>Actual Fibrillation</b> |   |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner                       | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how Injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |  |   |  |
| State Registrar   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D36655</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>May 12, 1999</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1185 Mt. Aetna Rd, Hagerstown, MD 21740</b>  |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>MAY 12 1999</b> |   | 32. Registrar's Signature<br> |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 16499

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Catherine Marie Jewell  |  |   |  | 2. Date of Death<br>Month Day Year<br>April 6, 1999  |  | 3. Time of Death<br>1:40am   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Heartland House   |  |   |  | 4b. City, Town, or Location of Death<br>Grasonville  |  | 4c. County of Death<br>Queen Anne's  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>216-09-4842  |  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>93 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 19, 1906   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10. Usual Residence of Decedent   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Md.   |  | 10b. County<br>Queen Anne's   |  | 10c. City, Town or Location<br>Queenstown  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br>6228 Main Street  |  |   |  | 10f. Zip Code<br>21658   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
| To Be Completed by Physician/Medical Examiner | 11. Merital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6<br>College (1-4 or 5+)   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Forelady --Seamstress  |  | 16b. Kind of Business/Industry<br>Perfect Garment  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>John Franklin Seward   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Florence Rebecca Clevenger  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Larry A. Jewell (Son)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6228 Main St., Queenstown, Md. 21658  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesterfield Cemetery   |  | 20c. Location - City or Town, State<br>Centreville, Md.  |  | 20d. Date<br>April 9, 1999   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Chel McSp...</i>  |  | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home<br>408 S. Liberty St., Centreville, Md.   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Arteriosclerotic cardiovascular disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |  |  |  | Approximate Interval Between Onset and Death<br>2yr  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Colon cancer  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |  |
|   | 29c. License number<br>D32036   |  | 29d. Date signed (Month, Day, Year)<br>4/6/99   |  |  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Gay J. Sproule 2108 D. Doran Drive Charter, MD 21619  |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>APR 07 1999  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 16500

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |                          |   |  |  |   |  |
|---|---|---|--|---|--|--------------------------|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Myrtle Irene Jordan                     |   |  |   | 2. Date of Death<br>Month Day Year<br>April 30 1999    |                          |   |  | 3. Time of Death<br>12:30AM                          |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>10814 Hilltop Dr. |   |  |   | 4b. City, Town, or Location of Death<br>Ft. Washington |                          |   |  | 4c. County of Death<br>Prince George's               |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>578-14-7124  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>96 Yrs.              |                          | 8. Date of Birth (Month, Day, Year)<br>08 01 02 |  | 9. Birthplace (State or Foreign Country)<br>Maryland |   |  |
|   | Usual Residence of Decedent   |   |  |   |  |                          |   |  |  |   |  |
| 10a. State<br>Maryland  |   | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Ft. Washington   |  |                          |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
| 10e. Street and Number<br>10814 Hilltop Dr.   |   |   |  | 10f. Zip Code<br>20744  |  |                          |   | 10g. Citizen of What Country?<br>USA   |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                          |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3 College (1-4or 5+)   |   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |                          |   | 16b. Kind of Business/Industry<br>At Home  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Richard Oliver DeVaughn  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Geneva Ridgeway   |  |                          |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Pearl Berry/Daughter  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as item 10  |  |                          |   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | Date<br>5/3/99           |   | 20c. Location - City or Town, State<br>Suitland, MD.   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home, P.A.<br>6160 Oxon Hill Rd. Oxon Hill, MD. 20745   |  |                          |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>multiple Myeloma</i><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |   |  |                          |   |  |  | Approximate Interval Between Onset and Death<br>8 years |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.  |   |   |  |   |  |                          |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|   |   |   |  |   |  |                          |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|   |   |   |  |   |  |                          |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                          |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
|   |   |   |  | 28d. Describe how injury occurred   |  |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  | 29b. Signature and title of certifier<br><i>William Tanner</i>  |  |                          |   | 29c. License number<br>D35206  |  |   |  |
|   |   |   |  | 29d. Date signed (Month, Day, Year)<br>April 30, 1999   |  |                          |   |  |  |   |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>William Tanner, M.D. 117201 Livingston Rd. Ft. Washington, MD. 20744  |   |   |  |   |  |                          |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>MAY 03 1999  |   |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |                          |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

